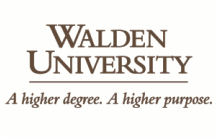

2017

Strategies for Managing the Shortages of Registered Nurses

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This is to certify that the doctoral study by

Jody-Kay Peterson

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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2017

Abstract

Strategies for Managing the Shortages of Registered Nurses

by

Jody-Kay Peterson

MA, Webster University, 2012

BS, Colorado State University – Pueblo, 2007

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

August 2017

Abstract

The purpose of this multiple case study was to explore strategies that healthcare facility leaders in Central Minnesota use to recruit and retain qualified nurses. Participants were 6 healthcare facility leaders including 2 nursing directors, 2 human resource personnel, 1 nurse supervisor/administrator, and 1 nurse recruiter who had the knowledge and experience in recruitment and retention of Registered Nurses (RNs) in healthcare facilities in Central Minnesota. The Herzberg 2-factor theory was the conceptual framework. Semistructured interviews were used to collect data. Data were analyzed using Morse's 4 steps data analysis process. The major themes were recruitment strategies and retention incentives. The recruitment strategies were the various hiring methods participants used to attract and gain RNs, and the retention incentives were the benefits that motivated and retained RNs. Participants relied on both recruitment strategies and retention incentives to manage the shortages of RNs. The results provide healthcare facility leaders with additional information about how to successfully recruit and retain qualified RNs, which may lead to a larger and potentially satisfied nursing population. Social implications include strengthening the nursing workforce, increasing productivity for healthcare facilities, providing better customer service and increased patient satisfaction, and contributing to more satisfied RNs and families, as well as helping the local communities and the economy.

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Dedication

I dedicate this doctoral study to my loving and devoted husband Levi, who has been my one true supporter throughout this process. Special thanks to my family, friends, peers, and co-workers who have supported and encouraged me along the way. Without all of you and your support, this journey would have been impossible. Thank you.

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Special acknowledgment to my chair, Dr. Jill Murray; I appreciated your guidance and support during this educational adventure. I acknowledge my SCM, Dr. David Moody, and my URR, Dr. Judith Blando for your feedback, eye for detail, and expertise. Dr. Blando, thank you for your efficiency and stepping in so quickly when I needed a URR. I acknowledge my peers from my 8100 and 9000 groups, especially Jamie King for your support, advice, sharing notes, encouragement, and contribution towards making this journey a success. Finally, thank you, Dr. Freda Turner, for being the compassionate, humble, and great leader that you are. I will never forget our encounters at both my residences. Thank you all.

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Section 1: Foundation of the Study

There is a shortage of Registered Nurses (RNs) in the United States (Chan, Tam, Lung, Wong, & Chau, 2013; Twigg & McCullough, 2014). As predicted by the Bureau of Labor Statistics (2013), the nursing shortage is expected to become worse. The heightened demand for more RNs is a result of an increased emphasis on preventative care, growing rates of chronic conditions, retirement of baby boomers, and an increasing life expectancy of Americans (Bureau of Labor Statistics, 2013 & 2015; Ortman, Velkoff, & Hogan, 2014). RNs support and coordinate patient care, educate patients and the public about health conditions, and give advice and emotional assistance to patients and their family members (Bureau of Labor Statistics, 2015).

Background of the Problem

Healthcare facilities require a specific ratio of nurses to patients to ensure patient safety and quality care (Heede et al., 2013; Spetz, 2013). When a workforce is understaffed, it can negatively affect the organization's performance and profitability (Chan et al., 2013). Because of the chronic nursing shortage, nurses often need to work long hours under stressful conditions. Longer working hours for nurses can result in stress, fatigue, injury, job dissatisfaction, job burnout, and lower patient care quality (Bae, 2012; Milliken & Clemens, 2007). Nurses working under these conditions are more susceptible to making mistakes and medical errors (Bae, 2012). Nurse burnout on the job increases infections, mainly, urinary tract and surgical site infections (Cimiotti, Aiken, Sloane, & Wu, 2012). Reducing nurse burnout can save patient lives as well as money for hospitals (Stimpfel, Sloane, & Aiken, 2012). The state of Pennsylvania alone

could prevent 4,160 infections if hospitals reduced nurse burnout from 30% to 10% (Cimiotti et al., 2012). Despite the 19% projected growth of employment for RNs through the year 2022, healthcare businesses struggle to retain and recruit adequate nurses (Bureau of Labor Statistics, 2015). Throughout this study, the term *nurse* is used interchangeably with RN.

Problem Statement

United States healthcare facility administrators will face an RN shortage of 1.05 million nurses by 2022 as 525,000 baby boomers near retirement (Bureau of Labor Statistics, 2013). Fifty-five percent of the RN workforce is age 50 or older (Budden, Zhong, Moulton, & Cimiotti, 2013). Inadequate staffing is increasing nurse burnout and stress levels, affecting job satisfaction, and forcing nurses to exit the profession (Ba, Early, Mahrer, Klaristenfeld, & Gold, 2014; Bae, 2012). The general business problem is that some healthcare facilities are experiencing nursing shortages. The specific business problem is that some healthcare facility leaders lack the strategies to recruit and retain qualified RNs.

Purpose Statement

The purpose of this qualitative multiple case study was to explore strategies that healthcare facility leaders in Central Minnesota use to recruit and retain qualified nurses. Participants were healthcare facility leaders which consisted of 2 nursing directors, 2 human resource personnel, 1 nurse supervisor/administrator, and 1 nurse recruiter who had the knowledge and experience in recruitment and retention of RNs in healthcare facilities in Central Minnesota. By the year 2025, Minnesota will need 20,330 new RNs

to meet the demand of quality patient care (Minnesota Department of Employment and Economic Development, 2015). The findings from this study may contribute to social change and benefit healthcare facility leaders by enhancing their knowledge of successful strategies to retain and recruit RNs. Improving healthcare facility leaders' knowledge of recruitment and retention strategies could minimize shortages in the nursing workforce. Nursing is the nation's largest health care profession (Bureau of Labor Statistics, 2015); investing in nursing has deep-rooted social and economic impacts. The nursing shortage negatively affects the quality and cost of patient healthcare. Inadequate staffing of nurses will lead to adverse patient outcomes, including mortality, and cause an increase in operating and labor costs (Chan et al., 2013).

Nature of the Study

Qualitative researchers aim to provide an understanding of how individuals interpret the environment in which they live or work, as well as how individuals, groups, and cultures perceive different phenomena (Malagon-Maldonado, 2014). Quantitative researchers examine the relationship between variables and use statistical methods of analysis (Ingham-Broomfield, 2015). Mixed methods research incorporates both qualitative and quantitative approaches to strengthen sociological explanation and simultaneously answer confirmatory and exploratory questions (Spillman, 2014). For this study, I chose to use the qualitative research method because of the alignment with my research question, which focused on peoples' lived experiences to understand social phenomena (Ingham-Broomfield, 2015; Turner & Danks, 2014). The quantitative research method did not apply because I did not measure relationships or differences

among variables. While mixed methods researchers can benefit from the best of both the qualitative and quantitative worlds (Spillman, 2014), I concluded that the mixed methods would be more time-consuming and complex than my study's purpose warranted.

Qualitative method includes five designs: (a) narrative (historical) research, (b) phenomenology, (c) grounded theory, (d) ethnography, and (e) case study (Malagon-Maldonado, 2014). The narrative design is storytelling in chronological order. The narrative design is used by researchers to interpret individuals' experiences through an examination of their stories (Robinson, 2015). Phenomenological researchers highlight the *what* and *how* of an individual's lived experiences (Dasgupta, 2015). Grounded theory is exploratory and highlights the past, which is counterproductive to this research. Ethnographers explore an entire culture-sharing group to describe and interpret shared and learned values, behaviors, beliefs, and language of a collective group. Case study researchers consider the study of a real-life present-day context or setting (Turner & Danks, 2014). The purpose of this study was to explore strategies that healthcare facility leaders in Central Minnesota use to recruit and retain qualified nurses. Using a case study design was appropriate for this study because case study researchers describe a certain activity, events, or series based on a specific phenomenon or issue of concern regarding a particular person, group, or institution specific to a time period (Baskarada, 2014).

Research Question

The focus of this qualitative multiple case study was to explore strategies that may provide valuable information that healthcare facility leaders could apply to minimize future shortages of RNs. The central research question was:

What strategies do healthcare facility leaders use to recruit and retain qualified nurses?

Interview Questions

The following interview questions related to human resource management strategies that nurse directors, human resource personnel, nurse administrator, and nursing supervisor use to recruit and retain qualified nurses:

- How do you track your recruitment strategies?
- How do you differentiate your successful recruitment strategies from less successful methods?
- What are some of your organization's most successful recruitment strategies for RNs?
- What are some of the barriers that you have encountered in implementing recruitment and retention strategies? How were those addressed?
- What are some of your current recruitment and retention barriers? How are you addressing those?
- What are some of your organization's recruitment strategies that have not been successful? Why were they not successful?
- How do you track RNs leaving your organization?
- What are some of the common themes or reasons why RNs leave?

- What are some common characteristics of RNs who stay versus RNs that leave? In what ways do you screen for those characteristics when recruiting?

Conceptual Framework

Frederick Herzberg developed the two-factor theory (Herzberg motivation-hygiene theory) in the 1950s (Herzberg, Mausner, & Snyderman, 1959). Herzberg's theory has two main factors that can cause job satisfaction and job dissatisfaction. The theory indicates that even though job satisfaction may decrease, it will not lead to job dissatisfaction as both factors act independently of each other. The opposite of job dissatisfaction is not job satisfaction. For the development of productivity and job attitudes, administrators must identify and address both job satisfaction and job dissatisfaction (Herzberg et al., 1959). Herzberg's distinguished between two types of factors: *motivators* (intrinsic) and *hygiene factors* (extrinsic). Motivators are those factors that catalyze positive satisfaction and promote motivation such as responsibility, personal growth, and recognition. Absent hygiene factors cause dissatisfaction and relate to work conditions, compensation, and organization's policies (Hackman & Oldham, 1976).

Employers can increase job enrichment for employees through the proper application of the Herzberg's theory. For employees to become involved in the planning, performing, and evaluation aspect of their jobs, management must encourage employee autonomy and enable and allow employees to create complete work units. Rather than through supervisors, management must provide regular and direct feedback to employees regarding productivity and job performance. Management must inspire employees to

take on new and challenging tasks (Hackman & Oldham, 1976). The two-factor theory was applicable to this study because individuals enter the nursing profession with a passion for caring for others, but at the same time stressful work conditions and the absence of hygiene factors are causing job dissatisfaction among nurses (Buja et al., 2013; Hussain, Rivers, Glover, & Fottler, 2012).

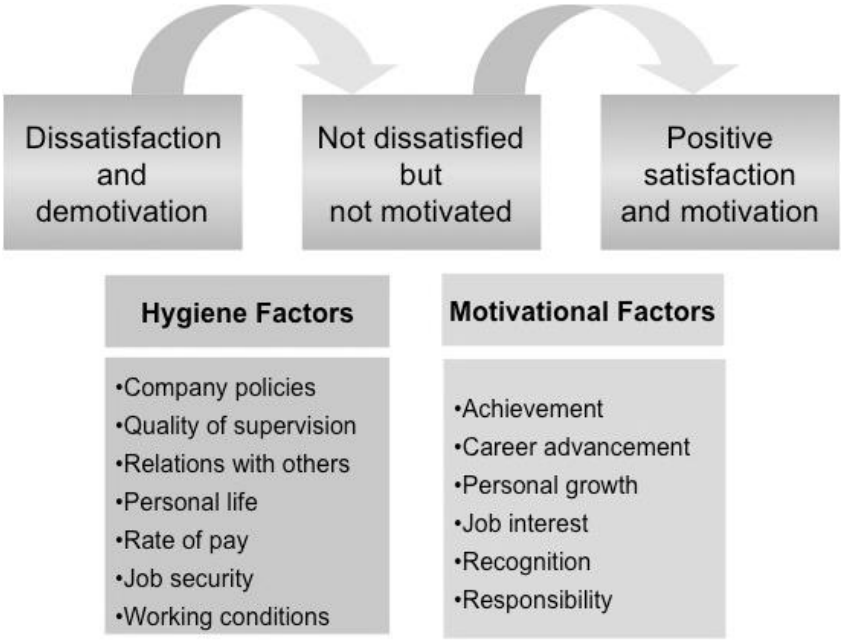

Figure 1. Chart of Herzberg's Two-Factor Theory. From Differencebetween.com, 2014, retrieved from http://www.differencebetween.com/difference-between-maslow-and-vs-herzberg-theory-of-motivation/. Copyright 2014 by Differencebetween.com

Operational Definitions

The following terms and phrases are defined as they appear in the doctoral study. These terms may not appear in everyday business language; however, a basic understanding of these terms as they relate to this study is necessary.

Abusive supervision: Abusive supervision is when a subordinate perceives supervisor to exhibit hostile behavior (verbal or non-verbal), not including physical

contact (Barnes, Lucianetti, Bhave, and Christian, 2015; Qian, Wand, Han, Wang, & Wang, 2015; Rodwell, Brunetto, Shacklock, & Farr-Wharton, 2014).

Baby boomers: Individuals born between the years of 1943 and 1960 are baby boomers (Brunetto, et al., 2013).

Handover: Handover is a two stage process at the end-of-shift transfer of patient care between outgoing and incoming nursing staff (Kitson, Athlin, Elliot, & Cant, 2013).

Job satisfaction: Job satisfaction is when an employee displays pleasurable or positive attitudes toward his or her occupation (Steele & Plenty, 2015).

Mentor: A mentor is a willing and accessible seasoned Registered Nurse that provides guidance to other nurses (Dyess & Parker, 2012).

Moral distress: Moral distress is an undesirable feeling that comes from an individual not able to conduct a moral action because of hierarchical restrictions (Oh & Gastmans, 2015).

Nurse recruitment: Nurse recruitment is the process of searching for, attracting, hiring, staffing, or employing additional nurses to ensure a supply of qualified nurses in the nursing workforce (Hussain, Rivers, Glover, & Fottler, 2012).

Nursing shortage: A nursing shortage exists when the nursing demand exceeds the supply of nurses needed for quality patient care (Atefi, Abdullah, Wong, & Mazlom, 2014; Zinn, Guglielmi, Davis, & Moses, 2012).

Strategy: A strategy is a plan of action (Liberman, 2013). A strategy is also a set of decisions for the future based on an organization's specific internal and external forces (Mishra, Mohanty, & Mohanty, 2015).

Succession planning: Succession planning is a strategic process that involves grooming the development of individuals and talents to replace specialty staff that is essential for an organization's future needs (Raftery, 2013).

Supervisor: A supervisor is someone acting on behalf of management to control and direct subordinates work tasks (Estes, 2013).

Transition shock: Transition shock is a misconception of awareness of practice and adjustment in a new role to include physical, intellectual, emotional, developmental, and sociocultural difficulties (Dyess & Parker, 2012).

Assumptions, Limitations, and Delimitations

This study may help as a guide to highlight strategies to deal with future RN shortages. This study includes certain assumptions, limitations, and delimitations, which I described below.

Assumptions

Assumptions are common beliefs interpreted as the truth, without proof (Schenkel, 2012). Assumptions are the foundation of the research that the researcher will embark upon (Kirkwood & Linda, 2013). My main assumption was that participants of the study would have the capability, the knowledge, the authorization, and the experience in the field of nursing. I assumed that the sample would be a fair representation of the nursing population. Marshall, Cardon, Poddar, and Fontenot (2013) highlighted the importance of a research design and having an adequate sample size to address the research problem. I also assumed that participants would be available, would be able to understand the questions asked, and would answer truthfully. All six participants were

available, understood the questions asked, and answered each question. Another assumption was that individuals might refuse to sign consent forms for recordings. No participants refused to sign consent forms.

Limitations

Limitations are those shortcomings or weaknesses which the researcher has no control over (Kirkwood & Linda, 2013). Limitations can influence the results of the study (Brutus, Aguinis, & Wassmer, 2013). The limitations of this study were participants could have withdrawn from the study at any time without consequences; participants' schedules could not have permitted availability, or participants would no longer be working for the same organization. No participants withdrew from the study and participants were available to meet. Another factor was that the possibility existed that the participants may have confidentiality clauses limiting responses.

Delimitations

Delimitations are the boundaries set by the researcher (Guni, 2012). Two delimitations were the particular research problem that I chose to investigate and the population of the study. Participants were at least 18 years old and had at least 1 year of experience in the nursing profession. The results of this study are not fit for generalization because the study focused on healthcare facilities in Central Minnesota and may not be applicable in other geographical locations or professions.

Significance of the Study

The results of this study will provide meaningful contributions to the nursing business practice and may be applicable to social change. The prolonged nursing

shortage will negatively affect the quality and cost of patient healthcare (Chan et al., 2013). The results of this study may provide healthcare facility leaders with additional information that can lead to increasing the nursing workforce and have a positive effect on retention.

Contribution to Business Practice

Researchers confirmed the nursing shortage in the United States and worldwide (Cowden & Cummings, 2012; Havens, Warshawsky, & Vasey, 2013; Itzhaki, Ehrenfeld, & Fitzpatrick, 2012; Rezaei-Adaryani, Salsali, & Mohammadi, 2012). The study results could provide possible strategies for healthcare facility leaders to apply to business practices to decrease the level of the nursing shortage. RNs are a significant component in the healthcare industry, and a continuation of inadequate staffing of nurses could lead to adverse patient outcomes, including mortality, and increases in operating and labor costs.

Implications for Social Change

Although the focus of the study remained specifically within healthcare facilities, the results could provide strategies for healthcare facility leaders to address future nurse shortages that will affect the economy at large and contribute to positive social change. Healthcare facilities acquiring and maintaining an ample supply of nurses will save more lives, prevent patient complications, prevent patient suffering, promote wellbeing, and save money for both healthcare facilities and patients' families. The health of the United States rests in the hands of RNs (Smolowitz, Speakman, Wohnar, Whelan, & Haynes, 2015).

A Review of the Professional and Academic Literature

The demand for RNs decreased in the early years of managed care organizations' (MCOs) as a result of cost reduction policies (Hussain, Rivers, Glover, & Fottler, 2012). MCOs resulted from the passage of the Health Maintenance Organization (HMO) Act of 1973, which was enacted by Congress in an attempt to restrain the growth of healthcare costs *(*Kant & Rushefsky, 2014). The demand for RNs increased in 1998 (Hussain et al., 2012). By 2020 over 75 million baby boomers are projected to account for one out of every four Americans (Hussain et al., 2012). Four hundred thousand nursing positions will become available in the USA by 2020 (Hussain, et al., 2012).

Although nursing has been the largest job growth of all professions in the United States, a shortage of nursing still exists (Zinne, Guglielmi, Davis, & Moses, 2012). A nursing shortage is predicted for every state by 2020 (Zinne et al., 2012). As a result of the existing shortage of RNs in the United States and worldwide, strategies for dealing with the future shortages of RNs shaped the formation of the study and the research outline

The purpose of a literature review is to provide an in-depth assessment of previous research and to furnish researchers with further research opportunities (Aggarwal, 2013). This professional and academic literature review enabled me to conduct a comprehensive analysis of the research theme and supported my research question. In this literature review, I investigated strategies for advancement and those strategies proven effective to recruit and retain RNs. The research gathered included

reasons for the shortage of RNs and the effect that the shortage has in the healthcare profession and patient care.

The Walden University Library provided me with valuable information for my literature review. I used multiple databases to provide a variety of method studies on the research topic using peer-reviewed articles published between 2011 and 2017. Articles before 2013 are included in this literature review because they contribute directly to the current research study or provide a background and foundation for the study. I searched databases including: EBSCOhost, ProQuest, SAGE Premier, Thoreau, and Google Scholar with words such as *registered nurses, the shortage of registered nurses, nurse retention, nursing turnover, nurse shortage, healthcare turnover, nurse supervisor, nurse management,* and *nurse leadership*. I used articles with content to provide me with information on the challenges of RN shortages and what strategies were used or recommended to overcome those challenges. The literature review consists of 144 peer-reviewed journal articles, where 90% are current sources were published between 2013-2017, within 5 years of the study. The remaining 10% of the peer-reviewed articles were published in the year 2011 and 2012. The remainder of this section contained further details on the conceptual framework of the study, followed by nurses' reasons for leaving their employment, profession, and the effects of the nurse shortage.

A passion for caring is a characteristic associated with one's entry into the nursing profession (Norman, Rossillo, & Skelton, 2016). Many nurses enter the profession not because of salary, but because they truly love helping others (Buja et al., 2013). Nursing is a unique profession worldwide because nurses want to make a difference in people's

lives, help people, and positively change their lives; however, when nurses believe that their workplaces are removing their capacity to care, they may elect to leave (Han, Trinkoff, & Gurses, 2015; Karnick, 2014).

Herzberg's theory or the two-factor theory (1959) was the guiding theory and the conceptual framework for this study. Herzberg's theory consists of two factors that may affect job retention and turnover; job satisfaction and job dissatisfaction are fundamental factors to retain employees and reduce turnover (Herzberg et al., 1959). Nursing is vital to the public at large and is grounded in principles of social justice and service to vulnerable populations (DeValpine, 2014). Herzberg's two-factor theory is over 50 years old, but the theory remained relevant for job satisfaction and was an excellent perspective with which to investigate strategies for dealing with future shortages of RNs.

Based on Herzberg's ideas, maintenance (extrinsic) and motivation (intrinsic) are two major factors that influence job satisfaction and job dissatisfaction (Smith & Shields, 2013). Atefi et al., (2014) further revealed three main themes that influenced nurses' job satisfaction and dissatisfaction: spiritual feeling, work environment factors, and motivation. Spiritual feeling related to nurses' religious faith, renewed energy (positive recognition from patients, patients' family members) and rewards from God (Atefi et al., 2014). Work environment factors include supportive and helpful colleagues, good work relationships, benefit and reward, working conditions, medical resources, leadership skills, work discrimination, and patient and doctor perceptions (Atefi et al., 2014).

Intrinsic motivation is what is interesting or satisfying to an employee (Hoye, 2013). Intrinsic factors aid in motivating employees (Herzberg et al., 1959; Sinha &

Trivedi, 2014). Intrinsic value motivates employees, enhances job satisfaction, and enriches job performance (Herzberg et al., 1959; Smith & Shields, 2013). Motivation factors are task requirements, professional development, and clinical autonomy (Atefi et al., 2014). Motivation factors relate to praise, recognition, advancement, work responsibility, self-efficacy, and self-esteem (Omar, Halim, & Johari, 2013; Smith & Shields, 2013). A decent wage is significant in retaining employees in their positions; however, wage is not the sole factor when selecting a profession or staying at a job. Other non-wage factors (such as organizational climate, workload, staffing levels, tuition reimbursement, and healthcare) influence job decisions (McHugh & Ma, 2014). Hoye (2013) found that employees who are satisfied with their job are intrinsically motivated to give positive referrals, while dissatisfied employees are likely to give negative referrals. Employees will remain in high demand and low paying jobs because of the intrinsic value that employees find within the work that they do and for the opportunity to help others (Smith & Shields, 2013).

Extrinsic motivation is a response behavior by the employer, such as a reward or punishment (Hoye, 2013; Omar et al., 2013). Sinha and Trivedi (2014) stated that extrinsic factors such as job security, promotion opportunities, and pay raise are equally important to each other to motivate employees. Maintenance factors entail environmental or organizational conditions that are outside of the employee's control such as benefits and salary (Smith & Shields, 2013). Problems with maintenance factors often result in job dissatisfaction (Smith & Shields, 2013).

The two-factor theory suggests that task performance will lead to high levels of satisfaction (Sinha & Trivedi, 2014). Increasing employee satisfaction and loyalty are precursors to improving service experience, patient satisfaction, and organizational performance in the healthcare field (Dahl & Peltier, 2014). Employee relationships with managers influence job satisfaction and commitment of employees (Sinha & Trivedi, 2014). Sinha and Trivedi (2014) found that intrinsic factors, work relationships, extrinsic factors, and individual relationships lead to higher level of job engagement and satisfaction.

Both maintenance and motivation factors have a positive effect on job satisfaction, but motivation factors have a stronger effect than maintenance factors (Smith & Shields, 2013). Job satisfaction is positively associated with performance and positively related to organizational commitment (Smith & Shields, 2013). Nurses working in hospitals with better work environments and better staffing have lower job dissatisfaction (McHugh & Ma, 2014). Job dissatisfaction is a predictor of intent to leave and job turnover (Smith & Shields, 2013). McHugh and Ma (2014) found that job dissatisfaction, work environment, and staffing were significantly connected with intent to leave. Nurses' job satisfaction came from teamwork, relationships with other nursing staff task requirements, professional development, and autonomy. Nurses' job dissatisfaction stemmed from reward, promotion, fringe benefits, high workloads, shortage of nurses, shortage of supplies and medical equipment, non-supportive managers, and unclear job descriptions (Atefi, 2014). Structural and financial bonds, along with nurse and physician social are integral components to improve job satisfaction

and retention of healthcare workers (Dahl & Peltier, 2014). Increasing nurses' job satisfaction and loyalty will contribute positively to reduce the nurse shortage (Dahl & Peltier, 2014).

Intrinsic motivation has been found to positively affect performance and well-being in the workplace (Guo, Liao, Liao, & Zhang, 2014). Poor work relationships result has a negative effect on both employees and patient outcomes (Brunetto et al., 2013). Understanding the intrinsic and extrinsic wants and needs of each generation will lead to fewer turnovers (Chung & Fitzsimons, 2013).

The Nursing Profession

The nursing profession in the United States is experiencing difficulties relating to recruitment and retention issues (Griffith, 2012). Rezaei et al., (2012) highlighted that nurses are the largest group of health professionals around the world. Spetz (2016) advocated that nursing is the human face of health care. The roles of nurses are complex and dynamic as a result of life and death situations (Paul & MacDonald, 2014). Organizations are negatively affected when experienced nurses leave, because tacit knowledge (unwritten or unspoken) is lost and the turnover contributes to the nursing shortage (Tummers, Groeneveld, & Lankhaar, 2013). Turnover leads to a waste of resources, affects the organization's normal operation, and increases management cost regarding recruiting, orientation, and training (Sokhanvar, Hasanpoor, Hajihashemi, Kakemam, 2016). The nursing shortage creates a ripple effect in healthcare delivery; hence, the need to attract and keep new nurses (Zinne et al., 2012).

Havens et al. (2013) and Chung and Fitzsimons (2013) indicated that the nursing workforce in the 21st century consists of four generational nursing cohorts: Veterans (born between 1925-1945), baby boomers (born between 1946-1964), Generation X (born between 1965-1980), and Generation Y (born between 1981-2000). The Veterans are the smallest cohort in the nursing workforce, while the baby boomers are the largest cohort and represent 42% of the nursing workforce; baby boomers are well skilled in practice, and baby boomers are also holding leadership roles (Havens et al., 2013). Generation X is replacing the baby boomers, and Generation Y is the second largest cohort in the nursing workforce (Havens et al., 2013). Chung and Fitzsimons (2013) argued that Generation Y nurses are the upcoming generation that will fill nursing vacancies. Generation Y will be 50% of the nursing workforce by 2020 (Sherman, 2014). However, concerns exist as to how interested or prepared Generation Y nurses will be to step into leadership roles (Gunawan, 2016; Sherman, Saifman, Schwartz, & Schwartz, 2015). Turnover intentions were the lowest among baby boomers, and Generation Ys were the highest (Brunetto et al., 2013).

Creating a workforce culture that engages all generations will lead to a high retention rate (Chung & Fitzsimons, 2013). Brunetto et al. (2013) found that employees who had a higher quality of supervisor-subordinate relationships had greater access to information, resources, and support which resulted in job satisfaction and lower turnover intentions.

Factors Affecting the Nursing Shortage

Nurse Faculty Shortage

A shortage of nurse faculty puts a strain on the size of the nursing workforce, which has a cumulative effect on the growing demand for RNs in the healthcare system (Gerolamo, Overcash, McGovern, Roemer & Bakewell-Sachs, 2014). The nurse faculty shortage presents a problem for the next generation of nurses and the quality of patient care (Cox, Willis & Coustasse, 2014). Two-thirds of the nursing schools pointed to an inadequate number of nursing faculty staff as the primary reason to reject 68,938 qualified nursing applicants in the United States in 2014 at the undergraduate level (American Association of Colleges of Nursing Report, 2015). Five main contributing factors to the nurse faculty shortage are: the need for advanced degree (doctorate); an aging academic faculty; financial restrictions connected with moving from clinical to academic roles; roles, responsibilities and the nurse faculty academic environment; and transition difficulties associated with the new-graduate nurse conversing to the registered nurse role (Cox et al., 2014).

Incentives assist in the support to retain nursing academia because more financially lucrative positions are available that can lure nurses away from the academy. Barriers such as faculty compensations, benefits, competing career opportunities, limited availability of nurse faculty positions, and nurse faculty workload are some of the major factors affecting the maintenance and attractiveness of a nurse faculty position (Gerolamo et al., 2014). Other incentives must be reinforced and expanded by employers to encourage more individuals to the field of nursing (Tellez, Neronde & Wong, 2013).

Job Burnout/Compassion Fatigue/Fatigue

Even though the growth rate (9.8%) of newly trained nurses is increasing roughly five times more than the projected demand rate (2.12%), the problem of retaining current nurses in the workforce remains (Chan et al., 2013). Multiple reasons contribute to the nursing shortage. Stimpfel et al., (2012) emphasized job burnout that affects nurses' job satisfaction and voluntary turnover. Long working hours and job burnout is common in human services jobs such as nursing (McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011; Qian et al., 2015).

Burnout is an extended reaction to chronic job-related emotional and interpersonal stressors; while compassion fatigue is a mixture of physical, emotional, and spiritual depletion connected with caring for major emotional and physically distressed patients (Sanchez, Valdez, & Johnson, 2014). Domen, Connelly, and Spence (2015) defined fatigue as a feeling of mental and physical exhaustion to continuous stimulation (exertion or stress). Fatigue avoidance strategies are practices to prevent fatigue (healthy sleep practices, and taking a nap before a long shift); while countermeasures are practices to suppress fatigue (activity breaks, standing, walking, and drinking caffeinated beverages) (Domen et al., 2015).

Dasgupta (2012) noted nurses constitute the biggest workforce in hospitals and work closely with patients, which as a result they experience multiple stressful work conditions (such as coping with terminally ill patients and their family, and insufficient staff to meet work demand). Nurses' job roles involve life-saving treatments and providing emotional support to patients (Ba et al., 2014). Patient support requires

excessive workloads, long and irregular work hours which are physically taxing, and conflict with nurses' family and social responsibilities (Abiodun, Osibanjo, Adeniji, & Lyere-Okojie, 2014; Qian et al., 2015).

Both job burnout and compassion fatigue can result in decreased workplace satisfaction, decreased patient satisfaction, and increased healthcare costs (Sanchez et al., 2014; Stimpfel et al., 2012). Dasgupta (2012) found that an increase in role overload, role conflict, and role ambiguity leads to disengagement and exhaustion. Burnout consists of disengagement and exhaustion and results in low nurse motivation and performance, which warrants poor patient care (de Vos et al., 2016). Nurses below the age of 25 showed a higher level of exhaustion than those of higher experience (Dasgupta, 2012). Prevention, assessment, and organizational intervention and commitment can curtail burnout and compassion fatigue (Ba et al., 2014). Prevention entails practicing mental, physical, and spiritual balance; and interventions include maintaining a healthy work/life balance and work-setting interventions (Sanchez et al., 2014). Religious nurses and nurses who value the social awareness of nursing services experience lower burnout levels (Kim, Han, and Kim, 2015).

Job Dissatisfaction

Despite efforts to improve job satisfaction in health care, job satisfaction has still been a long-standing concern (Roberts-Turner, Hinds, Nelson, Pryor, Robinson, & Wang, 2014). Wage is a significant component for good nurse results (McHugh & Ma, 2014). Low pay is the main aspect of job dissatisfaction for nurses (Kalandyk & Penar-Zadarko, 2013). Job dissatisfaction has influenced retention, recruitment, as wells as turnover in

the healthcare industry (Roberts-Turner et al., 2014). Positive work environments are pertinent to recruitment and retention of healthcare professionals (Nowrouzi, Rukholm, Lariviere, Carter, Koren & Mian, 2015). Choi, Cheung, and Pang (2013) revealed that nurses' perception of their work environment was related to their sense of job satisfaction and intention to leave their current positions. Nurses who are less satisfied and less committed to their occupation are more likely to think that they will not continue working in the current line of work until age 65 (Maurits, de Veer, van der Hoek, & Francke, 2015). Nurses' environment (staffing, resources, ward practice, management, and professionalism) also significantly predicted nurses' job satisfaction and intention to leave (Choi et al., 2013). Low job satisfaction will lead to absenteeism and high turnover (Abiodun et al., 2014). Turnover costs depend on multiple characteristics of hospitals and will change over time because of inflation (Li & Jones, 2013). Hospitals with less than 1,000 FTE RNs have significantly lower turnover costs compared with hospitals with more than 1,000 FTE RNs (Li & Jones, 2013). McHugh et al. (2011) recognized nurse's job dissatisfaction results in expensive labor disputes, turnover, and a threat to patient care. Li and Jones indicated that the estimated cost of a newly licensed RN turnover is $856 million for organizations. Rates of burnout, job dissatisfaction, and intent to leave will decrease if work environments and staffing improve (Kutney-Lee, Wu, Sloane, & Aiken, 2013).

Bragg and Bonner (2014) found that nurses resigned when their values do not match the organizational values regarding nursing practices; referred to as a misalignment of value between the nurse and the hospital. Leaders understanding the

relationship between empowerment and job satisfaction could reap benefits to implement strategies to retain nurses, and improve patient care outcomes (Zhang, Tao, Ellenbecker, & Liu, 2013). The three stages of value alignment occur before a nurse resigns: the first stage is sharing values (both organization and nurse share similar values); the second is conceding values (hospital values involved patient care), and the final stage is resigning (Bragg & Bonner, 2014). Healthcare managers' focus should be on job satisfaction as a retention outcome for nurses (Cicolini, Comparcini, & Simonetti, 2014). If not, resigning is the final stage when a nurse is unable to realign personal and organizational values and simply leaves the organization because the nurse underwent conflict, where the nurse believed that his or her professional integrity was severely compromised (Bragg & Bonner, 2014). Physical stress and emotional exhaustion reduce job satisfaction (Schwendimann, Dhaini, Ausserhofer, Engberg, & Zúñiga, 2016). High blood pressure, headaches, emotional stress, episodes of crying, palpitation, chest pains, and abdominal problems related to their work were some of the personal health issues that nurses described they experienced because of conceding values (Bragg & Bonner, 2014). Satisfying and healthy work environments support nurses' practice in the workplace (Cicolini et al., 2014).

Nurses who work in hospitals and have direct patient contact are more susceptible to higher job burnout and job dissatisfaction than nurses who work in other job settings (McHugh et al., 2011). Hospitals with more burnout and dissatisfied nurses have lower patient satisfaction. Chan et al. (2013) indicated that job dissatisfaction includes pay, opportunity advancement, workload stress, job burnout, and satisfaction with supervisor

and the organization. McHugh et al. (2011) added that nurses are also dissatisfied with their health benefits, retirement benefits, and poor work environments. Thirty-six percent of nurses in hospitals reported workload caused them to miss changes in their patients' conditions as well not being able to report vital information about patients during shift changes (McHugh et al., 2011).

Job satisfaction reduces turnover through increasing intent to stay, decreasing job search behavior (Al-Hamdan, Manojlovich, & Tanima, 2016). A high level of quality of work life also portrays nurses identifying in a positive manner toward the organization and increases loyalty to the organization (Peltier, Schibrowsky, & Nill, 2013). If nurses have a low level of quality of work life, they will develop the idea of leaving (Lu, Ruan, Xing, & Hu, 2015). New health care reform has highlighted the need and importance of patient care (McHugh et al., 2011). Improving nurse satisfaction, working conditions, and benefits for nurses will positively affect the stability of the nurse workforce in the future that will increase patient satisfaction (McHugh et al., 2011).

Longer Working Shifts

Stimpfel et al. (2012) posited longer shifts for nurses affect nurses' well-being and associate with a higher level of burnout, patient dissatisfaction, and intention to leave the job. Nurses' shift length is the difference between the beginning and end time of a nurse most recent shift worked. Nurses have been known to work long hours (Townsend & Anderson, 2013). A nurse's regular shift is 8 or 12 hours in length (Stimpfel et al., 2012). Many hospitals offer 12-hour shifts as the standard shift for nurses (Townsend &

Anderson, 2013). Nurses working more than 13 hours per shift experienced increased patients' dissatisfaction (Stimpfel et al., 2012).

Sixty-five percent of nurses worked shifts of 12-13 hours in hospitals deemed high-technology and more affiliated in teaching (Stimpfel et al., 2012). Seventy-five percent of hospital nurses work 12-hour shifts (Townsend & Anderson, 2013). Non-white male nurses excessively worked shifts that were 12 hours or longer; while, intensive care nurses were more likely to work longer hours than nurses in medical or surgical units (Stimpfel et al., 2012). Townsend and Anderson indicated that industrial research testified that employee productivity drops drastically after 10 to 12 hours of work. As nurses worked longer shifts burnout and an intention to leave the job increased steadily (Stimpfel et al., 2012). Nurse managers find nurses to work 12-hour shifts more manageable because that means fewer shifts to schedule and less daily handoffs (Townsend & Anderson, 2013). Nurses who worked 10-11 and more than 13 hours experienced higher job dissatisfaction (Stimpfel et al., 2012).

The nursing shortage phenomenon has resulted in nurses deprived of rest days, and nurses are more prone to work injuries because of a heavy workload (Choi et al., 2013). Barnes et al. (2015) noted that nurses sleep fewer than six hours in a night. Buja et al. (2013) validated shift work and night shifts have negative influences on nurses' health and well-being. Stimpfel et al. (2012) indicated the adverse effect of a hospital with working shifts of more than 13 hours for nurses, had a lower patient rating from patient dissatisfaction and patients would not recommend the hospital to family or friends. Domen et al. (2015) found more than 80% of Certified Registered Nurse

Anesthetists (CRNAs) reported experiencing call-shift fatigue; more than two-thirds reported experiencing physical or psychological symptoms when fatigued, and almost one-third (28%) reported committing an error in patient care because of fatigue. An excessive workload depletes workers' energy and makes recovery impossible (McHugh & Ma, 2014). CRNAs who work five call-shifts experience more call-shift fatigue (Domen et al. 2015). When nurses worked shorter shifts such as 8-9 or 10-11, patient dissatisfaction decreased (Stimpfel et al., 2012).

Handover Inconsistencies

Nurses work in shifts, and they perform handovers when their shifts are ending (Kitson et al., 2013). Continuing quality care and patient safety are dependent on effective communication (Johnson, Carta, & Throndson, 2015). Communication is an essential part of patient care and plays when conducting handovers (Kitson et al., 2013). When everyone on the care team practices effective communication, the entire team increases shared knowledge, goals regarding patients, and plan of care (Radtke, 2013). Gaps in knowledge about patients cause unnecessary delays in care (Johnson et al., 2015). Handovers by nursing team leaders in the intensive care unit contain diverse and inconsistent content (Spooner, Corley, Fraser, & Chaboyer, 2016). Kitson et al. (2013) discovered two main communication processes required for handovers: articulating the whole picture and providing detail patient information. Inadequate and inconsistent handovers can compromise patient safety (Johnson et al., 2015; Spooner et al., 2016). Nurse leaders are encouraged to monitor and have some form of standardized and

consistent model to determine nurses' communication behaviors particularly in handovers (Johnson et al., 2015; Kitson et al., 2013).

Insufficient Nurses

RNs staffing levels help to maintain job satisfaction (Kalisch & Lee, 2013). In the next coming decades, the importance of RN will continue to grow because of care delivery, technology, and a bigger emphasis on prevention techniques (Auerbach, Staiger, Muench, & Buerhaus, 2013). The insufficient nursing staff makes it difficult for active nurses to provide quality patient care (Cox et al., 2014). Inadequate nursing staff results in a multitude of adverse events from patient infections to patient deaths (Griffith, 2012). An insufficient supply of nurses increase infection rates in hospitals, attributes for more stress, and increase nurses' workload which results in nurse burnout and turnover (Cox et al., 2014).

Auerbach et al. (2013) refuted that some states in the United States do not have a nursing shortage; however, the Western and Northeast regions in the USA are still facing a nursing shortage challenge. Even though some states may have unprecedented levels of new RN graduates, the future of the RN workforce is still not secured and some uncertainties exist such as continuance of new entry growth which must continue to grow over the next two decades at a rate of 20%; uneven distribution of RN workforce; and the temporary growth of workforce will subside (Auerbach et al., 2013). The most important reason for nurses' intention to leave is insufficient development and career opportunities (Tummers, Groeneveld, & Lankhaar, 2013).

Workplace Incivility

Workplace incivility is characterized as a low unexpected behavior that is vague but has the intention to hurt the targeted individual, is a violation of workplace norms, and is another factor that adds to the nursing shortage (Spence Laschinger, Wong, Cummings, & Grau, 2014). Incivility in the nursing workplace can be destructive to the parties involved, the professional nursing practice, the organizational environment, patient safety, and the health of nurses (Hoffman & Chunta, 2015). Workplace incivility has the potential to affect employee health negatively, increased burnout, job satisfaction, commitment, and turnover in the nursing workforce (Rahim & Cosby, 2016; Spence Lachinge et al., 2014). Within the United States healthcare industry, workplace incivility costs an estimated $23.8 billion annually from absenteeism, turnover, productivity, and legal action. Lost productivity from workplace incivility cost an estimated $11,581 per nurse (Spence Lachinge et al., 2014). Torkelson, Holm, and Bäckström (2016) found that female and younger employees are more targeted by workplace incivility from coworkers, while younger employees and supervisors are slightly more prone to initiate incivility.

Nurses experience various forms of violence in the workplace such as bad language, raised voices, insulting, undermining nursing skills, spitting, pushing, or beating (Kalandyk & Penar-Zadarko, 2013). Nursing leaders create positive nursing work environments that retain and empower a satisfied nursing staff (Spence Lachinge, et al., 2014). Social support can buffer negative effects of workplace incivility (Sguera, Bagozzi, Huy, Boss, & Boss, 2016). The value of nursing leaders' relationships with

their staff promotes a supportive work environment, lower work incivility and burnout, as well as high job satisfaction for nursing staff and intent to stay in their positions (Spence Lachinge et al., 2014).

Abusive Supervision

A supervisor is someone acting on behalf of management to control and direct subordinates work tasks (Estes, 2013). Abusive supervision is a negative and damaging interaction between leaders and team members (Li, Wang, Yang, & Liu, 2016). Personal attacks, task attacks, or isolation can result in decreased job satisfaction, psychological strain, and higher intentions for nurses to quit (Mathieu & Babiak, 2016; Rodwell et al., 2014). Qian et al. (2015) and Wu and Lee (2016) revealed abusive supervision positively correlates with mental health problems of anxiety and depression among nurses. Abusive supervision affects nurses' outcomes and the climate of workgroups (Barnes et al., 2015; Priesemuth, Schminke, & Ambrose, Folger, 2014; Rodwell et al., 2014; Qian et al., 2015). Workplace abuse is nothing new and can trace as far back as the industrial revolution (Estes, 2013). Nurses' negative mental health from abusive supervision is costly for health institutions and society (Chu, 2014; Qian et al., 2015). Abusive supervision cost U.S. corporations an estimated $23.8 billion a year (Estes, 2013). Organizational leaders must promote a zero tolerance policy regarding abusive supervisions (Qian et al., 2015; Rodwell et al., 2014).

Estes (2013) found that the effect of abusive supervision resulted in decreased morale (67%), decreased productivity (41%), decreased nursing care delivery (36%), and increased errors (51%). Untargeted co-workers were also negatively influenced from

targeted subordinates directing their anger at them (Estes, 2013; Qian et al., 2015). Barnes et al. (2015) highlighted that some supervisors are often abusive, but others are not usually abusive. A psychopathic trait such as narcissism in supervisors is a precursor to abusive supervision (Mathieu & Babiak, 2016). An incident of abusive supervision occurred 46.6%, with 36.6% of RNs reported negative influence on performance and compliance (Estes, 2013). From the abuse, RNs displayed less focus efforts, less compliance to follow supervisors' instructions, physical, and psychological withdrawals/distress, avoiding the abusive supervisor via job transfers and resignations, and other counterproductive reactions such as taking longer breaks, punctuality issues, or daydreaming on the job (Barnes, 2015; Estes, 2013). Negative influence of abusive supervision affects nurses, patient care, patient satisfaction and organizational performance (Estes, 2013; Mathieu & Babiak, 2016; Qian et al., 2015).

Workplace Bullying

Bullying is constant harassment, horizontal, vertical or lateral violence, nurse hostility, abuse of power, intimidating, insulting, or disruptive behavior (Castronovo, Pullizzi, & Evans, 2015). Workplace mobbing is another term for bullying (Castronovo et al., 2015). Workplace bullying is widespread in nursing (Chu, 2014). Nurse bullying has happened for more than 100 years; however, a culture of silence exists regarding nurse bullying and hinders public awareness (Castronovo et al., 2015). Workplace bullying involves a variety of public hostile behaviors (Wilkins, 2014).

Workplace bullying is a growing occupational stressor among healthcare professionals (Wilkins, 2014). Nurse bullying has detrimental consequences to nurses

(physically and psychologically), patients (medication errors, deaths), healthcare institution (absenteeism, turnover, patient safety), and to the nursing profession (nurse shortage) as well (Castronovo et al., 2015; Chu, 2014). Additional consequences of workplace bullying include depression, anxiety, nightmares, psychosomatic symptoms, low morale, high absenteeism, and high job turnover (Wilkins, 2014). Workplace bullying affects other employees as well and is harmful to workers (Chu, 2014; Wilkins, 2014). Results of nurse bullying include an increase in patient mortality and nurse suicide (Castronovo et al., 2015).

Perpetrators of bullying are most often individuals within the nursing field (e.g. nurse managers, senior nurses, charge nurses, and nurse colleagues) (Castronovo et al., 2015). In the nursing profession, there are numerous reasons that individuals bully others; the two main factors are power and control by the person carrying out the bullying (Lee, Berstein, Lee, & Nokes, 2014). A bully is likely to be in a higher position; however, bullying between equals also exists (Wilkins, 2014). The higher the perpetrator's position makes it more difficult for nurses to report incidences of bullying (Castronovo et al., 2015). Hospitals are prone breeding grounds for workplace bullying because of female dominance; most bullying (68%) is same gender bullying (Wilkins, 2014). Bullying among new graduate nurses and new hires are shown to be higher (Castronovo et al., 2015). Bullied nurses could result in seeking alternate employment (Wilkins, 2014). Intelligence, competence, integrity, and accomplishment are some of the attributes that make individuals more susceptible to bullying in the workplace

(Castronovo et al., 2015). Bullied nurses are three times more likely to leave the nursing profession, compared to unbullied nurses (Castronovo et al., 2015).

Workplace bullying causes job stress, and job stress has the greatest cause of job dissatisfaction among healthcare providers (Wilkins, 2014). Most workplace bullying is never recognized, documented, or reported (Moore, Leahy, Sublett, & Lanig, 2013). The recommendation for nurses to channel workplace bullying is to use cognitive reappraisal to reframe perspective and associated emotional responses (Wilkins, 2014). The first step toward change and creating a healthy work environment is to admit that a bullying problem exists (Berry, Gillespie, & Gormley, 2016). Another suggestion is the role that humor plays in hope and optimism, where humor helps to transform negative mood into positive mood (Wilkins, 2014). Castronovo et al. (2015) proposed a value-based incentive payment in the Hospital Value-Based Purchasing program. This program would be a survey similar to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for the value-based incentive payment to measure nurses' viewpoints of workplace bullying and based on patients' quality of care and patient satisfaction during a baseline period (Castronovo et al., 2015). Hospital administrators can institute anti-bullying policies and practices to include established grievance procedures and proper investigation of complaints to combat nurse bullying (Chu, 2014). Nurse leaders, nurse educators, administrators, and government are urged to solve the nurse bullying issue by creating and implementing effective incentives for institutions and implementing a zero-tolerance policy (Castronovo et al., 2015).

Demographics

Al-Hussami, Darawad, Saleh and Hayajneh (2013) found that there was no relation or effect of age on turnover; however, on the contrary, Chan et al. (2013) advocated that nurses who are single and younger are more apt to leave than older married nurses. Hospitals with more highly educated RNs, ample staffing, and positive practice environments had more satisfied nurses and indicated more favorable patient outcomes (Twigg & McCullough, 2014). Males and those with a University education are more likely to leave (Chan et al., 2013). Nurses who had 9-18 years of work experience were more apt to stay in their current work settings than other nurses; nurses who had more than 30 years were more likely to leave their current positions for many reasons including retirement and increased workload (Nowrouzi et al., 2015).

Carter and Tourangeau (2012) findings indicated that nurses who were psychologically engaged in their jobs had a lower intention leave their current job. High employees' job engagement can be meaningful to employees' ongoing commitment (Albdour & Altarawneh, 2014). Female nurses, older nurses, nurses who were new to the organization or who had been there for more than 15 years showed lower turnover intentions (Carter & Tourangeau, 2012). Nurse work engagement influences the perspective of the nurse practice environment, job outcomes, and quality of care (Bogaert, van Heusden, Timmermans, & Franck, 2014). Nurse psychological engagement with work, work pressure, development opportunities, and support for work-life balance indicated the strongest relationship with intentions to leave; while perceived satisfaction of quality of patient care provided to patients indicated a weak relationship

and intention to leave (Carter & Tourangeau, 2012). A supportive work environment, supportive leadership from managers, structural empowerment in policy planning and goal setting, and opportunities for nurses to learn and develop can positively affect nurses' job satisfaction and retention rates (Chan et al., 2013).

Geographic Preference

In the United States, healthcare is a major industry that provides millions of jobs for individuals (Dotson, Dave, & Cazier, 2012). Rural hospitals, when compared with urban hospitals, face a tougher challenge with the nurse shortage and experience major difficulties in hiring and keeping a strong nurse workforce (Havens et al., 2013). Nurses in rural areas take on more responsibilities (Dotson et al., 2012). Ma, Yang, Tseng, and Wu (2016) found the work stress of nursing staff in urban hospitals was lower than that of nursing staff in rural hospitals. Many differences exist between rural and urban nurses such as education, age, and reasons for entering the nursing profession (Dotson et al., 2012).

Geographic location and economic reasons were some of the reasons for nurses choosing their current jobs (Dotson et al., 2012). Geographic differences are factors that influence turnover costs (Li & Jones, 2013). A nurse's employment decision is broken down into four categories: (a) economic, (b) structural, (c) psychological, and (d) locational desirability factors (Dotson et al., 2012). The level of job satisfaction influences rural nurse retention; rural nurses have significantly higher job satisfaction and lower job stress compared with urban nurses (Bratt, Baernholdt, & Pruszynski, 2014). Rural nurses are older, have longer nursing tenure, have fewer years of formal education,

and many nurses work in rural areas because of a nurse background, the rural lifestyle, and the opportunity to spend more time with family and friends (Dotson et al., 2012). Education and continuous professional development, regulatory, financial incentives, and personal and professional support are four types of intervention retention strategies to orient future rural and remote nurses (Mbemba, Gagnon, Paré, & Côté, 2013) distinguished. An increase in the availability of education will help rural areas to attract and keep nurses; small rural clinics may need to find nurses locally (Dotson et al., 2012).

Ethical Dilemmas

An ethical dilemma occurs when an individual perceives that a situation violates his or her sense of what is right and wrong (Rathert, May, & Chung, 2015). Ethics is a major element in nursing practice as nurses make decisions concerning various challenges such as patients' privacy rights and life and death situations (Choe, Kang, & Park, 2015). Ethics and nursing leadership have diminished because of role complexities and the changing context of the healthcare environment (Makaroff, Storch, Pauly, & Newton, 2014). Rathert et al. (2015) and Cerit and Dinc (2012) testified that ethical dilemmas and conflicts are imminent in healthcare settings. Many ethical dilemmas exist within nurses' practices that can lead to moral distress (Oh & Gastmans, 2015; Rathert et al., 2015). Ethical behavior is the daily expression of one's commitment and the display of one's moral integrity in times of crises (Makaroff et al., 2014). Nurses' ethical dilemmas can also stem from unsatisfactory alternatives, role expectations, and what information nurses decide to share with patients to enable patients to make informed choices regarding their health (Dwarswaard & van de Bovenkamp, 2015). Ethical

leadership, like ethical practice, is the responsibility of both senior leaders and employees within an organization (Makaroff et al., 2014). How a nurse responds to ethical problems depends on social and cultural factors, religion, professional experience, autonomy, and competency (Cerit & Dinc, 2012). Ethics must be upheld in organizational priorities (Makaroff et al., 2014).

An ethical climate is the shared perception (rules, individualism, and organizational interests) in an organization; moral distress is not being able to act with integrity because of organizational constraints (Atabay, Cangarli, & Penbek, 2014). Atabay et al. (2014) grouped moral distress under organizational constraints, misinformed and over-treated patients, and lack of time and resources. Moral distress has a negative effect on nurses, patient outcomes, and organizational results (Rathert et al., 2015).

As nurses grow older, compassion satisfaction increases and they experience less intense moral distress (Kim et al., 2015; Oh & Gastmans, 2015). Nurses with a bachelor's or higher degree experienced a higher intensity of moral distress when confronted with situations of medical ineffectiveness, than did nurses with an associate degree (Oh & Gastmans, 2015). Moral distress among critical care nurses will result in burnout, high turnover, and decreased the quality of care (Choe et al., 2015). The more often moral distress occurs, the higher the levels of emotional exhaustion, and depersonalization nurses have toward patients, where nurses will experience frustration, anger, consider leaving their positions, or leaving their jobs (Oh & Gastmans, 2015). Most end-of- life situations caused critical care nurses moral distress (Browning, 2013;

Henrich et al., 2016). As nurses experienced a higher level of moral distress, they significantly considered leaving their position more frequently (Oh & Gastmans, 2015).

Makaroff et al. (2014) found that formal nurse leaders were often hesitant to use ethical language and instead use *values* to refer to ethics. Often nurse managers are uncertain how to lead in ethical dilemmas (Zydziunaite & Suominen, 2014). The reason for the hesitation is that some formal nurse leaders believed that ethical language created distance between themselves and others (Makaroff et al., 2014). Kim et al. (2015) opined that intervention is needed by healthcare professionals to help nurses increase their professional quality of life about ethical dilemmas nurses face. Frontline nurses indicated that they valued supportive, stable, competent, visible, and responsive characteristics of their formal nurse leaders (Makaroff et al., 2014). Ethical conflicts become an obstacle to nursing service and nurse development (Kim et al., 2015). Formal nurse leaders are aware of the effects of not providing support or ethical leadership to their staff and described effects such as moral abandonment, distress, stress, moral stress, and anxiety in their staff when their staff did not receive support from them (Makaroff et al., 2014). Ethical decision-making requires independent reasoning and accountability (Cerit & Dinc, 2012). Nurses often quit because they experience moral distress and a lack of support to practice ethically (Makaroff et al., 2014). When nurses experienced more ethical dilemmas, their professional quality of life will be negatively affected (Kim et al., 2015). Formal nurse leaders acknowledged that frontline nurses and other staff are the faces of ethical care, and nursing leadership must provide frontline staff with support to

strengthen ethical practice (Makaroff et al., 2014). Ethical leadership can play a role in improving employees' health and well-being (Chughtai, Byrne, & Flood, 2014).

Healthcare organizations must ensure that organizational cultures, policies, and practices analytically evaluate nurses to act morally (Oh & Gastmans, 2015). To avoid ethical climate and moral distress, recommendations such as solving the nursing shortage, encourage participation in rules establishment, fostering autonomy, improving physical conditions, and expanding the health care budget are necessary (Atabay et. al., 2014). Intervention or educational programs assist nurses who are morally distressed (Oh & Gastmans, 2015). If not, then long-term nurses' experience of moral distress will prove detrimental to the healthcare system such as nurses leaving the organization, nurses leaving the profession, or nurses changing to less stressful jobs (Ba et al., 2014; Oh & Gastmans, 2015). Adding more nurses may reduce moral distress and improve the quality of patient care (Atabay et al., 2014). If nurses are successful in dealing with moral distress, personal change and growth are obtainable (Oh & Gastmans, 2015).

Work Stress

Nursing is a profession associated with high stress (Ba et al., 2014; Qian et al., 2015). The nursing profession is physically and emotionally challenging (Brennan, 2017). Chan and Wan (2012) noted work stress is the pressures that employees encounter and associate with job duties. The majority of nurses' stress comes from workload and work/home (Sakshi, SJai, & Singh, 2016). Stress varies among different hierarchical levels within organizations (Sinha & Subramanian, 2012). Stress can lead to high turnover rates and lessens the quality of patient care, especially among novice nurses

(Ba et al., 2014). Low, middle, and high-level managers experience numerous and different contributors to organizational role stress (ORS). ORS is stress resulting from an individual's role within an organization (Sinha & Subramanian, 2012).

Stress can come from good and bad life events where good stress is called eustress, and bad stress is called distress (Sinha & Subramanian, 2012). When employees experienced high-stress levels, they are more fatigued and perform more poorly than employees with lower stress levels (Chan & Wan, 2012). Stress can have devastating effects on nurses' levels of job satisfaction, compassion, fatigue, and burnout (Ba et al., 2014). Stress can result from ten organizational roles such as: inter-role distance, role stagnation, role expectations conflict, role erosion, role overload, role isolation, personal inadequacy, resource inadequacy, self/role conflict, and role ambiguity (Sinha & Subramanian, 2012).

Buja, Zampieron, Mastrangelo, Petean, Vinelli, and Baldo (2013) declared nursing is among the top 40 occupations with the highest frequency of stress-related disorders. High work stress impairs employee's service performance on tasks that require self-regulation (Chan & Wan, 2012). Nurses who worked shift work experienced self-reported stress, gastrointestinal, and musculoskeletal symptoms (Buja et al., 2013). Kalandyk and Penar-Zadarko (2013) found that 52% of nurses most frequent complaints were about backaches. Older nurses were often associated with spinal diseases, while younger nurses had allergies to disinfectants (Kalandyk & Penar-Zadarko, 2013). Night shift nurses identified with more job-related strain, musculoskeletal symptoms, more

back pain, lower decision authority, and higher physical and psychological job-related demands than day shift nurses (Buja et al., 2013).

Self-regulation is the personal intrinsic resource that employees can draw from to cope with work stress (Chan & Wan, 2012). Identifying and managing ORS will provide the opportunity to enhance organizational effectiveness and facilitate the health of employees (Sinha & Subramanian, 2012). Reallocating human resources, redesigning interventions to enhance employee's perception of task control, training employees, providing supportive supervisors, and boosting employee's job motivation are some of the ways that managers can control stressed frontline employees (Chan & Wan, 2012). Human resource managers should cultivate a supportive work culture that will assist managers in lessening employee's role stress (Sinha & Subramanian, 2012).

Sustainable Leadership

Coaching and mentoring aid in the development of a nurse's leadership and managerial capability (Griffith, 2012). The performance of organization leadership depicts a role in nursing management (Zydziunaite & Suominen, 2014). Sustaining leadership capital continues to be a challenge for many organizations (Griffith, 2012). Transformational, authoritative, and sustainable leadership strongly link with the satisfaction of the professional needs of nurse management (Zydziunaite & Suominen, 2014). Roberts-Turner et al. (2014) observed that both transactional and transformational leadership have a positive influence on RN job satisfaction. The ownership is on senior organizational leadership to plan for leadership succession accordingly at the

management, leadership and frontline levels to prevent organization disruptions (Griffith, 2012).

Nurse leaders can be more effective as leaders by strategically using their strengths and counteracting their weaknesses (Manning, 2016). A ready, talented, and capable supply of nurse leader is needed more than ever before to provide quality patient care and improve patient satisfaction (Griffith, 2012). Peer groups and mentors help nurse managers to develop as future leaders and decision-makers (Vesterinen, Suhonen, Isola, Paasivaara, & Laukkala, 2013). When the nursing staff is inadequate, the problem lies in poor management and leadership (Griffith, 2012). When RNs perceived that their nurse leaders inspire, encourage, and hold them accountable for their actions, RNs are more satisfied in their roles (Roberts-Turner et al., 2014). Nurse leaders must embrace change and act as change agents (Griffith, 2012). Hospitals should outline visions of nursing leadership and management for the future (Zydziunaite & Suominen, 2014). Succession planning is a necessity for the growth and stability of the nursing profession; therefore, an effective succession process is to identify, recruit, develop and mentor/coach employees (Griffith, 2012).

The Affordable Care Act (ACA)

For the healthcare system in the United States to become more effective to an aging population and increasing healthcare costs, healthcare needs reformation (Smolowitz, Speakman, Wohnar, Whelan, & Haynes, 2015). Adding to the strain of the nursing shortage, the Affordable Care Act (ACA) is responsible for more than 30 million more Americans qualified for health insurance (Cox, 2014; Smolowitz et al., 2015; Tellez

et al., 2013; Wallis & Kennedy, 2013). Such demand will result in a ratio of RNs to a population of 1000 to 100,000 (Wallis & Kennedy, 2013). The essential roles and responsibilities of the healthcare professionals, including RNs, must be re-conceptualized and optimized to meet the growing demand for RNs (Smolowitz et al., 2015). As a result of the ACA, the U.S. government has already called for an increase in the number of healthcare providers to care for millions of Americans eligible under the Act (Barnes, 2015). The opportunity also permits for RNs to be given more leadership role to contribute positively to strengthening the larger primary care system (Smolowitz et al., 2015). Cunningham (2013) stated that the healthcare reform would cause shortages of health professionals and even worsen the current shortages. A benefit to increasing nursing demand is that RNs can practice at their full scope of their license, where measurable value to cost savings and quality of care are imminent (Smolowitz et al., 2015). Spetz (2014) made mention that the ACA is likely to result in the hiring of more skilled RNs. Effective quality care is also possible from collaboration among group health professions (Smolowitz et al., 2015). To be successful in this fast growing sector, RNs will need robust education in areas such as community health, social and psychological services, and general management (Spetz, 2014). The nation's health depends on RNs (Smolowitz et al., 2015).

Transition Shock

Transition is significant changes to roles, goals, and responsibilities (Azimian, Negarandeh, & Fakhr-Movahedi, 2014). A personal sense of well-being, increased confidence and competence, mastery of skills, and autonomous practice are all attributes

of a successful transition; while an unsuccessful transition entails negative emotions, a lack of support, and limited support (Barnes, 2014). The lack of welfare facilities in healthcare settings, multiple long working hours, shortage of nursing staff, ineffective on-the-job orientation courses, poor professional accountability, and commitment contributed to nurses' coping with transitions (Azimian et al., 2014). A newly licensed RN is an individual practicing nursing between 12-18 months (Dyess & Parker, 2012). New nursing graduates experience into the workforce has been a transition shock because of unsupportive work environments (Boamah, & Laschinger, 2015). Zinne et al. (2012) mentioned that it takes at least one year for a nurse to become proficient in a job. Newly graduated nurses need 12-18 months to adjust to their roles (Chenevert, Jourdain, & Vandenberghe, 2016). Acute healthcare organizations are fast pace and complex; such an environment can be overwhelming for new RNs (Phillips, Kenny, Esterman, & Smith, 2014).

Zinne et al. (2012) stressed the need for residency programs to transition new nursing students from a school environment to provide bedside care quickly in a hospital. In nursing practice, experience supports skill acquisition and develops proficiency (Barnes, 2015). Nurse residency programs increase retention, decrease turnover, provide a safe learning environment, development of supportive environments, and provide new graduate nurses with the tools and resources for success in the professional workforce (Zinne et al., 2012). The transition process can be exciting but at the same time very stressful and challenging for new RNs (Kaihlanen, Lakanmaa, & Salminen, 2013). When graduate nurses experienced negative perceptions in the first 60-90 days of their new role

and environment, often that lead to turnover within the first year (Rush, Adamack, Gordon, Lilly, & Jank, 2013). The benefits of supporting residency programs are also grand whereby the opportunity facilitates developing and growing one's own nurse (Zinne et al., 2012). Well-trained preceptors can effectively influence transition, first-year turnover, nurse retention, and possibly improve patient safety (Clipper & Cherry, 2015). The military has a healthy nurse workforce and is seen as an exemplary organization because of its incentives and training programs for its nurses (Zinne et al., 2012). Mentorship roles are significant in the transition process as they guide nursing students and new nurses in their clinical learning process and professional development (Kaihlanen et al., 2013). When nurses are fully educated and experienced, patient care is positive (Zinne et al., 2012). Education and staff training and development assist in preparing nurses for transitions (Azimian et al., 2014; Barnes, 2015).

Support on the job was rated the lowest as new graduate nurses reported bullying on the job (Boamah & Laschinger, 2015). Inadequate nurses' transitions on the job are linked with outcomes such as nurses' burnout, job dissatisfaction, and high staff turnover (Azimian et al., 2014). New nurses are more apt to resign within their first year of practicing as a result of lack of experience (Zinne et al., 2012). Nurse managers could restructure the work environment to empower nurses and especially new graduate nurses, to increase their engagement and to decrease their intent to leave to combat the nurse shortage issue (Boamah & Laschinger, 2015). Transition support is necessary for nurse retention (Dyess & Parker, 2012). Nurses' access to information, support, resources, and

opportunities for professional growth is critical to nurses' positive work experience, such as job satisfaction and commitment (Boamah & Laschinger, 2015).

Portrayal of the Nursing Profession

Nurses image (NI) has consistently been a challenge to the nursing workforce (Rezaei-Adaryani et al., 2012). Word-of-mouth can provide both positive and negative source of information for recruitment (Wolfe, 2014). The attribute of NI is a complex multidimensional factor (Rezaei-Adaryani et al., 2012). Negative word-of-mouth and word-of-mouse (online social forums) have contributed to the shortage of nurses (Wolfe, 2014). Social media communication has become a cultural trend (Hwong, Oliver, Kranendonk, Sammut, & Seroussi, 2017). Negative interpersonal information can drastically affect the attractive of any organizations for employment more than a formal advertisement (Wolfe, 2014). Popular images of the nursing profession are often negative which hurts the nursing profession and plays a role in recruitment and retention of nurses (Weaver, Salamonson, Koch, & Jackson, 2013).

The antecedents of NI include the media, poor communication and invisibility, nurses' clothing styles, nurses' behavior, gender issues, and professional organizations (Rezaei-Adaryani et al., 2012). Popular media reinforce stereotypes about nursing which may enhance or damage the appeal of nursing to potential students, as nurses are often not portrayed in medical shows, doctors are instead (Weaver, et al., 2013). The public image of nursing is diverse and incongruous (Hoeve, Jansen, & Roodbul, 2013). Many television programs of nursing images were incorrect, unrealistic, lacking facts, misleading, and represented poor nursing role models (Weaver et al., 2013).

Some consequences of NI include jeopardizing resource allocation, staff recruitment and nursing shortage, interdisciplinary relationships, nurses' job performance, violence again nurses, public trust, low pay, workload, burnout, and job dissatisfaction (Rezaei-Adaryani et al., 2012). Wolfe (2014) crucially highlighted that word-of-mouth and mouse are not the core problem that is creating the nurse shortage, but the work environment instead. Improving NI would substantially benefit the recruitment and retention of nurses (Rezaei-Adaryani et al., 2012). Positive role models will certainly provide some recruitment benefits regarding raising the profile of nursing (Weaver, et al., 2013). Improving the work environment and pursuing strategies to foster a positive work environment can correct the portrayal of the nursing profession (Wolfe, 2014).

The posting of certain information (such as home address, mobile number, sexual orientation, political, religious views, and foul language) online publicly is causing ethical and legal challenges for the nursing profession (Levati, 2014). Social media enable conversation where organizations have no control (Gretry, Horváth, Belei, & Riel, 2017). Although the behavior of nurses on Facebook was harmless, there were a few identified examples that were not in line with the relative codes of conduct in the Nurse Deontological Code (Levati, 2014). Smoking and alcohol consumption are contradicting behaviors as nurses are supposed to promote a healthy lifestyle (Levati, 2014). Nurses advise patients of health promoting knowledge to influence patients to change their risky health habits (Hornstern, Lindahl, Persson, & Edvardsson, 2013). Unhealthy lifestyles are a large problem and supporting individuals to prevent, and self-manage illness has the

potential to alleviate the pressure on health care services caused by workforce shortages (Hornstern et al., 2013). The image is determined regarding how nurses and the public perceive nursing (Hoeve et al., 2013). The Nurse Deontological Code states that nurses should protect their dignity and the image of the profession at all times (Levati, 2014).

Fifty percent of experienced nurses do not recommend a career in nursing (Chenevert et al., 2016). Neilson and McNally (2012) found significant others such as parents, family, guardians, guidance teachers, and career advisors had a strong influence on the career choices of 5th and 6th-year school students. These significant others often steer high academic achieving students from a nursing career path (Neilson & McNally, 2012). Nurses are normally praised for their virtues and not for their knowledge (Hoeve et al., 2013); therefore, high academic achieving students can do something better than nursing as a career (Neilson & McNally, 2012). Nurses are well-trained professionals, but the public views nurses as a low-status profession (Hoeve et al., 2013). Neilson and McNally (2012) highlighted the information and views that given to 5th and 6th-year school students from significant others regarding nursing seemed to be negative and outdated. The nursing profession continues to suffer based on the influence of social and cultural norms (Hoeve et al., 2013). Significant others can be targeted to curtail the global nurse shortage (Neilson & McNally, 2012).

Language and Cultural Differences

Nurses continue to migrate across international borders (Dywili, Bonner, & O'Brien, 2013). Skilled nurses are infamously unstable throughout the world (Pittman, 2013). The international migration will continue to exist because of globalization, as

long as there are push and pull factors and freedom of movement (Dywili et al., 2013). Barnell, Nedrick, Rudolph, Sesay, and Wellen (2014) testified that a diverse workforce can be challenging based on many factors (such as cultural differences, language, and communication).

Language and cultural differences cause major and frequent misunderstandings regarding nurse and patients (Crawford, Candlin, & Roger, 2015). Individuals experience more communication barriers when different parts of the world interconnect because of the global context (Dai & Weng, 2016). Linguistics and applying three main theoretical frameworks (process model of intercultural communication, conversational reference, and interactive framing) can aid in better understanding intercultural communication (Crawford et al., 2015). Having the ability to communicate effectively with individuals from different backgrounds and culture is critical to high-quality patient care and safety (Papadopoulos, Shea, Taylor, Pezzella, & Foley, 2016). When individuals share the same cultural experience or background, communication is easier (Crawford et al., 2015). Bleich, Macwilliams, and Schmidt (2015) advocated that nursing diversity should mirror the patients they serve. Crawford et al. (2015) found that communication misunderstandings between nurses and patients arose from pronunciation, word stress, intonation and speech delivery, grammar, vocabulary, and style of self-presentation.

Lack of Nurse's Autonomy

Organizational support assists in facilitating autonomy in nurses' practice (Twigg & McCullough, 2014). Hospitals that support a participative management style or when leadership is accessible, have lower rates of intention to leave (Heede et al., 2013). Trybou, Gemmel, Pauwels, Henninck, and Clays (2013) uncovered that RNs who had a high level of organizational support and a high level of interpersonal social exchange with their head nurse are more likely to depict extra-role behavior. Within the nurse practice, occasionally a situation presents itself for a nurse to make an independent (autonomy) decision (Twigg & McCullough, 2014). Allowing nurse's autonomy to make decisions, participation in hospital governance, and participative management, are valuable techniques for retaining nurses (Heede et al., 2013). When employees experience their work environment as empowering, they are more likely to encounter higher intrinsic motivation to improve their work environment (Chu, 2014). Nurses are more likely to stay in their work setting when they view themselves to have control of their practice and adequate autonomy (Tummers et al., 2013). Nurses need to know of their leadership support in their decision making in taking risks. By providing educational opportunities in critical thinking, evidence-based practice, and defining nurses' role and status within the organization, are methods in which leaders can encourage nurse autonomy (Twigg & McCullough, 2014).

Transition and Summary

Section 1 comprised of the core components of this study. The background of the problem addressed the importance of the nursing profession and presented a brief overview of the nursing shortage in the United States. The foundation identified the problem statement, the purpose of the study, and justified the qualitative multiple case study as the most suitable research method and design for the study. Questionnaires were used to interview healthcare facility leaders that were based on the central research question and supported interview questions. Hertzberg's theory was the conceptual framework for the study. Section 1 contained the significance of the study. The literature review provided comprehensive analyses of prior research, allowing for a better insight into the understanding of the underlining reasons nurses leave their employment, profession, and the effects of the nurse shortage.

Section 2, which defined the study, included specific details of the nature of the study, the participants, the role of the researcher, and how the research was conducted. Section 3 contained the findings of this study relating to Hertzberg's theory, application for professional practice, implications for social change, recommendations for action, and additional future research to recruit and retain qualified nurses. Section 3 also included personal reflections and personal biases about the research.

Section 2: The Project

Purpose Statement

The purpose of this qualitative multiple case study was to explore strategies healthcare facility leaders in Central Minnesota use to recruit and retain qualified nurses. Participants were 2 nursing directors, 2 human resource personnel, 1 nurse administrator, and 1 nursing supervisor who had knowledge and experience in recruitment and retention of RNs located in healthcare facilities in Central Minnesota. By 2025, Minnesota will need 20,330 new RNs to meet the demand of quality patient care (Minnesota Department of Employment and Economic Development, 2015). The findings from this study may contribute to social change and benefit healthcare facility leaders by enhancing their knowledge of successful strategies to retain and recruit RNs. Improving healthcare facility leaders' knowledge of recruitment and retention strategies could minimize shortages in the nursing workforce. Nursing is the nation's largest health care profession (Bureau of Labor Statistics, 2015) and, investing in nursing has deep-rooted social and economic influences; the longer the nursing shortage exists, the more the quality and cost of patient healthcare will be negatively affected. Inadequate staffing of nurses will lead to adverse patient outcomes, including mortality, and increase in operating and labor costs (Chan et al., 2013)

Role of the Researcher

The researcher is important to ensure the quality of the research process (Gunaydin & McCusker, 2015). A researcher's key purpose in data collection is to be an observer and a neutral interviewer (Hardicre, 2013; Mahnaz, Bahramnezhad, Fomani,

Mahnaz, & Cheraghi, 2014; Postholm & Skrovset, 2013; Purdy & Jones, 2013). My tasks were to connect, listen carefully, and understand participants' viewpoints. I probed and encouraged participants to clarify or expound upon any information that was unclear or insufficient. Another role of the researcher is to know exactly which data sets to hone in on and the appropriate tools to use to analyze them and provide an in-depth understanding and interpretation of the content for meaningful insights and trustworthy outcomes (Mahnaz et al., 2014; Moon, 2015; O'Sullivan, 2015). I did not have any prior relationship with the research topic of strategies for managing the shortages of RNs, or potential participants, or area.

I acted in accordance with *The Belmont Report* regarding ethical principles involving human subjects (U.S. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). The Belmont Report has three ethical principles for researchers: (a) respect for persons – protecting individual rights/welfare; (b) beneficence – maximizing benefits, minimizing risks; and (c) justice – fair distribution of benefits and burdens of the research (U.S. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). My first step was to receive approval from the Walden's University Institutional Review Board (IRB) to protect the rights of participants before seeking out any participants for the study or data collection. My IRB approval number for this study is 12-19-16-0432388.

Many ethical challenges, such as incorrect interpretations or bias, are present in qualitative studies; the researcher must develop and establish the necessary guidelines to overcome ethical challenges and amplify research integrity (Mahnaz et al., 2014; O'Sullivan, 2015). Researcher bias is something to be aware of and monitor; however, a bit of researcher bias is needed and is inevitable (Fusch & Ness, 2015). To eliminate researcher bias in research is removing the researcher altogether; removing the researcher would eliminate the need for the researcher to form questions, recruit participants, and for participants to tell about their lived experiences (Moon, 2015). I mitigated research bias by incorporating member checks (participants' validation of data interpretation), data triangulation (multiple data sources), and journaling (Elo, Kaariainen, Kanste, Polkki, Utriainen, & Kyngas, 2014). I employed a reflective journal to record personal thoughts and feelings immediately after each interview. I refrained from interpreting data through my personal lens and used participants' data as a guide to data analysis.

In qualitative research, data is collected with a focus on multifaceted interviews to produce a description of the experiences (Mahnaz et al., 2014). I used an interview protocol outlining the procedure for conducting interviews (see Appendix A). I conducted semistructured interviews as part of a single case study. I treated participants equally and I asked participants the same interview questions in the same order. One of my tasks as a researcher was to contribute to creating an environment of trust for participants to answer truthfully during the interviews (Collins & Cooper, 2014; Purdy & Jones, 2013). Postholm and Skrovset (2013) noted that honesty is often received in return when individuals are honest. My final step of data collection was to organize data

by categorizing themes and reporting applicable findings truthfully without distorting participants' events and feelings (lived experience) or misrepresentations.

Participants

The selection of participants is the initial step to data collection in research (Englander, 2012). Participants for this study were individuals who were at least 18 years old, knowledgeable, and had the necessary background and current experience in recruiting and supervising RNs. The participants served in the rank or the capacity as a healthcare facility leader such as 2 nursing directors, 2 human resource personnel, 1 nurse supervisor/administrator, and 1 nurse recruiter. The participants were individuals who provide services regarding recruitment and retention of RNs in Central Minnesota healthcare facilities.

My strategy for identifying and recruiting participants was first to seek out and locate contact information for potential participants via the Internet about major healthcare facilities in Central Minnesota, and through the nurses' professional network such as the Minnesota Nurses Association. I acquired contact information such as general information, administration, and executive staff and leadership from each institution's website page, after which I gained access to participants via telephone calls and emails. Participants were interviewed face-to-face until I reached data saturation. Data saturation occurs when adequate data is received to support the study (Fusch & Ness, 2015; Kaur, 2016). Each participant's story served as a single case study to gather information to answer the study's research question. Lewis (2015) indicated that case

studies might be utilized to draft successful stories that are used to demonstrate the effectiveness of programs.

The relationship between a researcher and participants builds rapport and connection (Collins & Cooper, 2014; Postholm & Skrovset, 2013; Purdy & Jones, 2013). The strategy I exercised to establish a working relationship with potential participants was first to provide an introduction of myself via email or telephone. I ensured that participants were adequately informed to understand the moral aspects of the research, including the research question via the consent form. In order to build rapport, I gave each participant a 3.1 fluid ounce of Voss water immediately after reviewing the consent forms, which they all appreciated. I thoroughly explained and assured participants that all information will be kept confidential. Participants had the opportunity to choose a nearby location that allowed an environment free from distraction and judgment for participants to share their experiences honestly. Participants are more open to sharing honest information when the environment is comfortable and free of judgment (Lewis, 2015). A good rapport between the researcher and participants enabled participants to provide access and yield valid data (Collins & Cooper, 2014; Lewis, 2015). Resnik (2015) indicated that it is important for the researcher to promote transparency and openness in research involving human participants.

Research Method and Design

Research is defined as a systematic and thorough process of investigation with the objective to describe phenomena and develop and examine explanatory concepts and theories that will contribute to a scientific body of knowledge (McCusker & Gunaydin,

2015). Qualitative, quantitative, and mixed methods are the three research methodologies that researchers use to investigate research topics (Fassinger & Morrow, 2013; McCusker & Gunaydin, 2015). I examined the three methods and found the qualitative method to be the most appropriate research method to explore strategies for dealing with the future shortages of RNs.

Research Method

Qualitative research is used to explore and examine subjective human experience by using non-statistical methods of analysis (Ingham-Broomfield, 2015). Qualitative research is crucial in healthcare environments because it can be used to investigate outcomes to receive and provide better patient care (Malagon-Maldonado, 2014). Qualitative research uses inductive data analysis to learn about the meaning participants hold about a problem or issue by pinpointing themes or patterns (Lewis, 2015). Malagon-Maldonado (2014) noted that because healthcare facilities are complex and critical, qualitative research is very beneficial in health design to improve the environment of care and provide insights into strategies for development. Qualitative designs are holistic and naturalistic, as the researcher does not tamper with the participant's experiences (Dasgupta, 2015). The qualitative method via interviewing participants' and allowing them to explain the phenomena provided the best answers for the study. Question format was open-ended to encourage participants to open up and give extensive responses about the strategies to deal with shortages of RNs. The qualitative research method is flexible and allows for open-ended questions, greater spontaneity, and interaction between the researcher and participants (Barnham, 2015;

Johnson, 2015; Kaur, 2016). Qualitative research is a key component in developing effective health strategies and interventions (Lewis, 2015).

Quantitative research, on the other hand, focuses on numbers and seeks to confirm hypotheses about phenomena (Caruth, 2013; Johnson, 2015; Kaur, 2016; McCusker & Gunaydin, 2015). The objective of this research was not to predict any answers or to make an educated guess about the research topic. Quantitative research method is fairly inflexible and question format is base on closed-ended questions via surveys, questionnaires, and structured observation (McCusker & Gunaydin, 2015).

Mixed methods research incorporates both qualitative and quantitative methodologies and draws on the strengths of each method to obtain valid research conclusions (Caruth, 2013; Kaur, 2016; Landrum & Garza, 2015). Many researchers supported the claim that mixed methods research can be difficult for a single researcher as a result of multiple data collection steps, requiring multiple resources, and is filled with complexities in that the researcher must be versed in both methodologies to effectively integrate data conversion and interpretation (Caruth, 2013; Hesse-Biber, 2015; Kaur, 2016; Landrum & Garza, 2015; McCusker & Gunaydin, 2015). Mixed methods research is time-consuming and can take many years to complete (Hesse-Biber, 2015). Because of time constraints, the mixed methods research was not suitable for this study.

Quantitative research aim is to answer questions such as *how many* or *how much*; while qualitative answers the *what*, *how*, or *why* (Barnham, 2015; Maxwell, 2016; McCusker & Gunaydin, 2015). My goal was to answer the *how* of nurse retention; therefore gathering data without specific participants and their personal viewpoints was

not a valuable approach. Ingham-Broomfield (2015) confirmed that qualitative research, when compared to the quantitative method, is better suitable to generate information to aid nurses in clinical decisions. The qualitative research method was the best fit for the research problem because I sought to understand the strategies that healthcare facility leaders are using to combat the shortages of RNs.

Research Design

Narrative, phenomenology, grounded theory, ethnography, and case study research designs are the five qualitative research methods (Lewis, 2015; Malagon-Maldonado, 2014). While the five research designs use similar data collection techniques (interviews, observations, and documents), the purpose of the study is what differentiates them (Reeves, Peller, Goldman, & Kitto, 2013). Narrative researchers focus on weaving together a sequence of events in date order to tell a personal story of past experiences (Korpi, Peltokallio, & Piirainen, 2014; Robinson, 2015). Phenomenological researchers aim to understand the meaning of participants' lived experiences (Roberts, 2013). The objective of grounded theory is to provide an explanation, and develop or discover a theory (Engward, 2013; Johnson, 2015), which was not the purpose of the study.

The ethnographical researcher immerses his or herself into the participants' everyday environment to experience the culture first hand so as to understand it (Rashid, Caine, & Goez, 2015; Reeves et al., 2013). Ethnographers explore culture to learn about social interactions, behaviors, ethnicity, religious activities, and languages within a group (Rashid et al., 2015; Reeves et al., 2013). The study objective was not to explore cultural norms of RNs; therefore, ethnography was not an appropriate design for this study.

Case study involves a deeper understanding of a real-life situation via various types of data sources to explain, explore, or describe an individual, group, or phenomenon in a detailed way that the reader can understand (Baskarada, 2014; Hoon, 2013; Starman, 2013). Even though the phenomenological is to understand a particular issue, it does not provide an in-depth meaning that the case study will offer for this study. I rejected the narrative, phenomenological, grounded theory, and ethnographical research designs and chose the case study design to allow for multiple unique perspectives of the research topic. Houghton, Casey, Shaw, and Murphy (2013) recognized that multiple case studies allow for comparisons, particularly in diverse settings. Multiple cases normally lead to more robust outcomes than single case (Baskarada, 2014). I used multiple case studies, analyze each case as a singular case, and then compare each case with each other. The qualitative researcher strives to obtain data saturation when participants have no new information to report (Engward, 2013). I reached data saturation when I heard no new information from participants.

Population and Sampling

Sampling is a representation of a whole population (Emerson, 2015). Recruiting the appropriate number of participants is crucial to the success of research (Englander, 2012; Newington & Metcalfe, 2014). In qualitative research, size does not mean significance and researchers need to move beyond *how many*, but rather to explore different representations of an issue (Bagnasco, Ghirotto, & Sasso, 2014; Guetterman, 2015; O'Reilly & Parker, 2012). Fusch and Ness (2015) addressed that researchers

should focus more on data richness (quality) and thickness (quantity), rather than sample size for the best opportunity to reach data saturation.

The sampling method I used for this study was purposive sampling technique. Purposeful sampling provides the opportunity to learn a great deal about issues of central importance and the potential to attain relevant, rich, and useful information (Baskarada 2014; Benoot, Hannes, & Bilsen, 2016; Guetterman, 2015). Unlike random sampling that selects a diverse group of participants, I used purposive sampling by first contacting healthcare facilities in Central Minnesota for specific participants who had the responsibility, experience, and capacity to provide information on the strategies used to recruit and retain qualified nurses. Purposive sampling provides rigor to qualitative research and allows the researcher to choose the most appropriate candidates for the study who can best answer the research questions (Baskarada, 2014; DeFeo, 2013). Data saturation will be evident when no new data, evidence, or themes are attainable from participants (Guetterman, 2015). Failure to reach data saturation has a negative impact on the quality and content validity of a study's results (Fusch & Ness, 2015). I ensured data saturation occurred via multiple interviews, reviewing documents, and observing behaviors to confirm transferability of the research.

Interviews are guided conversations and are one of the most vital sources of case study evidence (Baskarada, 2014). Interviews are main data collection procedure for qualitative human research that allows for richer and more in-depth nuances of information (Englander, 2012). I used semistructured interviews to be flexible and to refocus questions to prompt participants for more information. Semistructured interviews

facilitate the opportunity to ask multiple participants the same questions (Baskarada, 2014). I scheduled interviews by spacing them out to allow myself ample time of analysis of the objection and appropriate recovery time between interviews of participants (data collection). By doing so prevented risk of emotional exhaustion or fatigue to both myself and participants (Mahnaz et al., 2014). This purposive sampling consisted of six healthcare facility leaders who have the knowledge and experience in recruitment and retention of RNs in Central Minnesota healthcare facilities. I conducted interviews at healthcare facility leaders' business places to accommodate their schedules.

Ethical Research

Research ethics guidance instructs that researchers are to maintain the principles of respect for persons while conducting human subjects research (Hayeems, Miller, Bytautas, & Li, 2013). I provided participants with information about a brief background of the study, the study's disclosure, participants' potential role, and how their input will benefit the study and the improvement of the nursing shortage. Consent is what justifies exposing individuals to risks to obtain scientific knowledge (Resnik, 2015). Participants' informed consent is an integral part of ethics in research and will be given before any data can be collected from participants (Mahnaz et al., 2014). Participants were informed about secure data storage, anonymity, and confidentiality to avoid or minimize potentially harmful impacts on the participants or the associated organization. Participants were notified that they have the option to withdraw or opt out from the study at any time without penalties (Mahnaz et al., 2014; Spece, 2013). Participants did not

receive any monetary incentives for contributing in the study but will receive a thank you letter and a copy of the final research document.

Rashid et al. (2015) indicated that ethics goes far beyond a consent form, but assuring participants that their privacy and confidentiality of information are well preserved. Failure to protect participants from risk, frequently leads to public commotion and will have severe consequences for the researchers and the scientific community (Resnik, 2015). Participants' names are kept confidential and protected as I assigned each participant a numerical number (e.g. participant 1). Participants' contact information and organizations are anonymous and removed from the study. Paper files will be in a locked cabinet, and electronic data will password protected on my personal computer. Based on Walden's University IRB requirements, I will store data collected from participants for no more than 5 years. After 5 years data collection and participants' information will be destroyed via shredding hard copy documents and burning electronic data. Walden University IRB ensures compliance with the University's ethical standards as well as the U.S. Federal regulations. The Walden University IRB approval number for this study is 12-19-16-0432388.

Data Collection Instruments

A researcher is considered as the research instrument (Mahnza et al., 2014; O'Sullivan, 2015). I was the primary data collection instrument for this study. I conducted semistructured face-to-face interviews with open-ended interview questions to gather quality and in-depth data from participants to understand the RN shortage phenomenon about the recruitment and retention of RNs. Anyan (2013) noted that

interview is a highly used method of collecting data in qualitative research that enables individuals to talk candidly about their experiences and understandings. The interview instrument (see Appendix D) was used as a guide to direct participants' conversations toward the research topic. Based on the permission of participants, I employed a tape recorder in the data collection process.

Reliable research findings are when another researcher can repeat the same data collection procedure and obtain the same results (Baskarada, 2014). If the findings of a research lack validity or justification, then the study itself is futile (Caruth, 2013). As part of the data collection process, I incorporated member checking to enhance reliability and validity of data collection. Member checking is the process of returning transcripts or repeating information, descriptions, or interpretations to participants for confirmation, validation, and for establishing credibility and accuracy of data gathered (Harvey, 2015; Houghton et al., 2013; Johnson, 2015; Rashid et al., 2015). Data triangulation involves the use of multiple sources of data to collect and analyze data that enhances the reliability of results and the attainment of data saturation (Fusch & Ness, 2015; Reeves et al., 2013). I collected relevant data via companies' websites, company records, and archival documents from participants regarding recruitment and retention strategies for data triangulation.

After interviewing each participant in person at each participant's company facility, I hand transcribed participants' responses and performed transcript review for data accuracy by giving participants the transcriptions to read through. Supplying participants with the transcribed data will allow participants to provide feedback on my

interpretations of their responses to ensure that I have captured their information and that I accurately represented their views and lived experiences. Caretta (2016) advocated that member checking complements data triangulation. Member checking should occur following transcription rather than after analysis so participants can acknowledge their responses (Houghton et al., 2013). Member checking happened after participants reviewed and verified transcripts. Before data analysis, participants' responses to each question were paraphrased and emailed to participants for review and accuracy. Participants were allotted one week to review and respond. Once I attained data saturation, I analyzed the data, and organized the information into themes.

Data Collection Technique

The primary technique that I used to collect data was via semistructured face-to-face interview. Semistructured interviews include the usage of open-ended questions where participants are all asked the same questions in the same order, and allowing the researcher with the flexibility to probe for additional participants' responses (Anyan, 2013; McIntosh & Morse, 2015). Jones (2014) reiterated that the most common method for conducting interviews is face-to-face. I conducted interviews at times that were convenient for participants who chose environments that allowed them to speak freely and without interruptions. The interview protocol (see Appendix A) was used as a standard guide to outline the procedures and method to elicit data and for conducting all interviews. Participants were emailed the consent and the confidential agreement forms before performing any interviews. See Appendix C for participants' invite letter and Appendix D for letter of cooperation.

I took notes to record significant phrases, repeated words, and nonverbal cues during interviews to document my insights pertinent to data collection and analysis. My notes were included in my analysis to formulate themes and findings. Theron (2015) indicated that a researcher could commence the coding process while in the data collection process by circling, highlighting, or underlining significant words or sentences while taking notes; however, these codes may change later. With the permission from participants, I used a digital recording application on my Galaxy S6 smartphone as an audiotape recorder in the interview process to aid with data coding and analysis. My Sony M-425 Pressman microcassette voice recorder was a backup recorder. I am competent with my smartphone application audiotape and Sony voice recorders which I have used several times in the past.

An advantage to face-to-face interviews is that the researcher has the capability to see participants' facial expressions and body language which may be useful in the data analysis; however, on the contrary, some participants may be nervous or uncomfortable with face-to-face conversations (Wilson, 2016). Face-to-face interviews are time-consuming (Irvine, Drew, & Sainsbury, 2012); however, the face-to-face interview method has a high response rate, and participants' responses are spontaneous (Opdenakker, 2006). Face-to-face communication is often considered the richest mode of communication (Butler, 2015).

The focus of a pilot study is to address issues of uncertainty in a small-scale preliminary study in preparation for a larger scale study (Lancaster, 2015). After Walden's IRB approval, I used two individuals to conduct a field test to ensure that the

questions were clear and that the interviews would not exceed one hour. Field test participants were not part of the actual participants nor were their feedback included in this study.

Member checking is a data collection technique also known as participant validation that enhances trustworthiness and pursues the credibility of results (Birt, Scott, Carvers, Campbell, & Walter, 2016). Member checking increases credibility, validity, and verify the content of interpreted data (Theron, 2015). To ensure clarification of a few responses, one follow-up telephone interview was done and audiotaped in my enclosed quiet home office. Other participants' follow-ups were done by email to review and verify transcripts to ensure accurate explanations captured.

Data Organization Techniques

Data organization is defined as the transcription of interviews and sorting and arranging of data (Theron, 2015). After each interview, I immediately hand transcribed participant's interview verbatim from tape recording into a Microsoft Word document. Verbatim interview transcripts showcase every exact word said by participants, which can retain robustness in qualitative research and may enhance readers' engagement (Butler, 2015). Each participant was labeled from P1 through to P5 for confidentiality purposes. Each participant verified the transcribed information to permit for member checking. I used a reflective journal to record my observations, insights, and notes taken during the interview. The purpose of a reflective journal is to record and review interactions, personal learning experiences to enable critical thinking and allow for deeper meaning and understanding (Lew & Schmidt, 2011).

Once all data was collected and verified, I coded, sorted, and organized data accordingly. Data coding is vital to data analysis and is a method to sort and organize data so that the data become clearer to the research (Theron, 2015). A researcher codes data to attach a descriptive meaning to represent data (St. Pierre & Jackson, 2014). Codes and themes were transferred to Microsoft Excel spreadsheets further break down that generated reports for data analysis. Learning a new software can be time-consuming and challenging (Chowdhury, 2015). I am competent with Microsoft Excel and chose to use this software instead of NVivo, Atlas.ti, or QDA Miner which I have no experience with. All raw data (information about each participant, collected documents, companies' websites information, transcribed interviews, and interview notes) will be in a locked cabinet and a password protected computer accessible to only me. After 5 years of study completion, all raw data will be destroyed by shredding hard copy documents and burning electronic storage media.

Data Analysis

Data analysis is a process of describing, classifying, and interconnecting phenomena with the researcher's concepts (Graue, 2015). Data is analyzed by identifying emerging and recurring themes and then making deductions from it (Theron, 2015). Graue (2015) emphasized that the core of data analysis is identifying properties of categories, examining relationships where the researcher stops describing but starts to explain why things are as they are. Data analysis represents a central step in qualitative research that uncovers patterns and is greatly dependent on the researchers reasoning abilities (Chowdhury, 2015; Mayer, 2015). To analyze the data, I employed Morse's

(1994) four steps data analysis process. According to Morse (1994), the first stage of analysis is to comprehend the data (broad coding), the second process is to synthesize (pattern coding memoing), third is to theorize (distilling and ordering), and fourth is to re-contextualize (developing propositions) the data.

Triangulation helps to validate claims via using multiple sources to cross-reference data such as observation, interviews, collection of documentary materials, audio recordings, videos, and artifacts. Triangulation allows the researcher to gain a better knowledge that strengthens the reliability of findings due to the variety of approaches (Graue, 2015; Mayer, 2015). I collected and checked documents received during interviews for authenticity, credibility, and representativeness. I analyzed data from sources such as participants' responses, companies' websites, my field notes, my reflective journal, and also from collected documents. I fully disclosed and discussed information relating to member checking of data with participants.

I made interpretations and drew meaning from the data by comparing contrasts, noting patterns, ideas, commonalities, and themes from the six participants interviewed (St. Pierre & Jackson, 2014). I described how themes and concepts derived from the data. My analysis was not limited to issues that I thought were important, anticipated themes, but issues that participants raised such as emergent themes. My analysis was supported by sufficient data to allow the reader to assess. I grouped participants' words, phrases, and events that appeared to be similar in the same category. I used *voice* in the text (participants' quotes) to illustrate themes described. The researcher can present quotes (data) from interviews that are meaningful, significant, and most representative of

the research findings (Anderson, 2010). Categories were re-examined from raw data to determine how they are linked to assemble the big picture into a story line. I incorporated a visual data display to show the connection between themes. Graue (2015) and Noble and Smith (2014) stressed that displaying the data must be clear to the reader. The interpretations should be evident in participants' contributions (Anderson, 2010).

Computer-assisted qualitative data analysis software can be very helpful when it comes to data management and analysis; however, software is incapable of understanding or give meaning to text, cannot replace the analytical skills of the researcher, and also there can be a bit of learning curve in maneuvering how to use the software (Chowdhury, 2015; Murphy, Shaw, & Casey, 2015; Noble & Smith, 2014). Microsoft Word was used to transcribe interviews, where I then deployed text codes and themes to Microsoft Excel to support data evaluation and analysis. I provided descriptions of how analyzed data arrived using the computer-aided software. Anderson (2010) indicated the analytical approach should be described in detail and theoretically justified in light of the research question as the reader must be aware of enough information to be able to carry out similar research. The process of data analysis is to assemble data in a meaningful manner that is transparent, accurate, and detailed while being factual to participants' responses (Noble & Smith, 2014). I ensured that the analyzed themes aligned with the research question to produce the information identified in the purpose statement through linking the themes to some of the major themes that have arisen in the literature. I analyzed themes to connect to the study's conceptual framework of Herzberg's theory, by re-examining established

topics and critically used the framework as a guide to collect, analyze, interpret data, and explore themes.

Reliability and Validity

Reliability

In qualitative research, data analysis depends on the researcher's intuition to reach conclusions and must showcase transparency for interpretations (Darawsheh, 2014; Lub, 2015). Reliability and validity are key components in corroborating qualitative research results (Sousa, 2013). Reliability refers to the consistency and validity (*truth value, trustworthy*) is using the appropriate tools, processes, and data for answering the research question (Leung, 2015; Lub, 2015).

Dependability is the constancy of the data over similar conditions (Cope, 2014). I first ensured dependability in my study by employing a pilot test to certify that the interview questions are distinct and understandable for participants to answer the research question effectively. I incorporated member checking of data interpretation and transcripts. I used data codes that are meaningful and present data analysis and interpretation that are truthful to participants' responses. At each stage of the research process, I documented and highlighted decision trials to allow for other researchers to concur with the decisions or to arrive at the same results. Cope (2014) recognized a study is dependable if the study findings duplicate with comparable participants in similar situations.

Validity

Credibility refers to the truth of participant's views portrayed accurately by the researcher (Cope, 2014; Theron, 2015). To enhance credibility, I described engagement, methods of observation, and audit trails. An audit trail is meticulously documenting and noting the researcher's assumption and decisions, which supports credibility and dependability (Baskarada, 2014; Cope, 2014; Darawsheh, 2014; Lub, 2015). Member checking aided me with accurately interpreted data. As researchers extract data from original sources, it becomes vital for researchers to compare constantly and verify interpretations for accuracy (Leung, 2015). For triangulation, the usage of several authentic data sources applied to draw conclusions such as interviews, observations, and companies' websites and documents to help corroborate evidence. Triangulation strengthens the validity of case study evaluation (Lub, 2015; Yin, 2013). A qualitative study is credible if the descriptions of human experience instantly identified with individuals that share the same experience (Cope, 2014).

Transferability is how applicable findings can be to other groups (Cope, 2014). I provided detailed and in-depth explanations of data findings to allow for transferability. This study audience is the health industry. For this study to be transferable, the results must apply to the health industry to combat future shortages of RNs by providing healthcare facility leaders with recruitment strategies and retention incentives information. Researcher bias can certainly interfere with the research process (Darawsheh, 2014). Self-reflections were done at the end of each interview to revisit highlights of each interview and record notes of participants' behaviors. Reflexibility is

the continuous process of self-reflection during the research and bracketing is a technique used to diminish the possibility of damaging effects of prejudices that may taint the research (Darawsheh, 2014). I practiced reflexibility and incorporated bracketing to help with researcher bias (Cope, 2014).

Cope (2014) highlighted that confirmability is the researcher's ability to exhibit that the represented data is solely from participants and not the researcher's predispositions or opinions. To demonstrate confirmability, I provided rich participants' quotes and outline clearly how findings came directly from the data. I ceased interviews and data collection when participants had no new themes to report, no new relationships between categories, and when I reached a point in the data analysis that acquiring more data will not lead to more information related to the research question.

Transition and Summary

Section 2 included specific details of the nature of the study, the participants (to include population and sampling), the role of the researcher, research ethics, and how I conducted the research via data collection, techniques, organization, and analysis showcasing the reliability and validity of the study. Section 3 included the findings of this study relating to Hertzberg's theory, application for professional practice, implications for social change, recommendations for action, and additional future research in recruiting and retaining qualified nurses. Section 3 also disclosed personal reflections, personal biases on the research, and the conclusion of the study.

Section 3: Application to Professional Practice and Implications for Change

Overview of Study

The purpose of this qualitative multiple case study was to explore strategies that healthcare facility leaders in Central Minnesota use to recruit and retain qualified nurses. I conducted five semistructured interviews with six healthcare facility leaders who had over 1 year of recruitment and retention experience of RNs in Central Minnesota. I collected data including interviews, company documents, observations from participants, and companies' websites using the data collection protocol approved by the Walden University IRB (approval number 12-19-16-0432388).

The interviews took place in private meeting rooms at each company's facility. The interviews were audio-recorded, transcribed, and then coded. I used Microsoft Excel software to distinguish and analyze major themes from data sources I received from participants' interviews. By using Microsoft Excel, I was able to triangulate the data and associate themes, phrases, and codes among data collection sources. Based on the data analysis of interview responses and company documents provided by the participants, the following four sub-themes: (a) job opportunity/recruitment, (b) student clinical, (c) patient focused, and (d) turnover/leave shaped the two major themes emerged during analysis: theme (a) recruitment strategies and theme: (b) retention incentives. The identification of similar terms, phrases, and themes among participants' data sources provided me with an understanding of participants' experiences and a combination of evidence to substantiate my findings.

Presentation of the Findings

The study's central research question was: What strategies do healthcare facility leaders use to recruit and retain qualified nurses? Participants in the study responded to interview questions based on their experiences of creating and implementing strategies to recruit and retain RNs in Central Minnesota. Participants were from the HR, nursing, talent and acquisition, or recruitment departments within the healthcare facilities. The study's findings are of significance to those leaders in healthcare facilities that recruit and retain RNs in the healthcare industry. To present my findings, the study participants are referred to as:

1. C1 for Company 1, which is a teaching hospital, and P1 for its representative participant.
2. C2 for Company 2, which is a teaching healthcare system, and P2 for its representative participant.
3. C3 for Company 3, which is a healthcare system which specializes in homecare, childcare, and medical staffing, and P3 for its representative participant.
4. C4 for Company 4, which is a healthcare facility, and P4 for its representative participant.
5. C5 for Company 5, which is a teaching healthcare system. Two leaders participated in the interview, and $P5^1$ and $P5^2$ for its representative participants.

I used semistructured interviews consisting of nine questions to collect data from participants. I interviewed six leaders. The average interview time was around 27 minutes. During or after the end of each interview, participants provided me with

supporting company documents such as recruitment and retention reports and job announcement ads. Data saturation began to recur at the third interview onwards until the fifth interview. After five interviews, I reached data saturation, where no new information emerged, and no further interviews were needed.

Once I completed the interviews, I hand transcribed the recordings. Participants were emailed the transcripts for transcript review. Transcript review ensures that the correct views were captured and are free from errors (Houghton et al., 2013). Participants were given 1 week to review and make corrections on the transcripts. After I had made corrections, each participant's responses were copied and pasted to wordcounter.com to rank the most frequently words used.

Keywords

I created a list of keywords from data sources to formulate the themes. Table 2 highlights the relevant words and terms most frequently used by participants in their responses.

Table 1

Word/Term Frequency: Over 10 Uses in the Interview Transcripts

Word/Term	Count
Job Opportunity/Recruitment	133
Student/Clinical	64
Patient Focused	27
Turnover/Leave	11

After reviewing each of the interview questions and participants' responses, I coded the data by using Microsoft Excel features for better clarity of each of the interview questions and answers. I followed the same process with the supporting documents and company websites to achieve methodological triangulation. Company websites provided information on recruitment such as job vacancies, compensation, and employment benefits for each organization. While coding, the themes began to emerge. Below I have provided a general summary of participants' responses to each interview question. An in-depth discussion of how the themes developed and how the themes correlate with the conceptual framework and literature will follow later in this section.

Interview question 1: How do you track your recruitment strategies? All participants conducted some form of recruitment tracking. P1 used a more technological research approach through a special group in their service center that is dedicated to only keeping tabs on current recruitment trends, what is working, and what is not working for the organization regarding recruitment activities. P2 employed multiple and thorough cross-check avenues for RN recruitment tracking. These avenues include weekly reviews, end of year reports, directives from Congress, recruitment plans, and benchmarking via Microsoft Word and Excel documents, Intranet SharePoint software, and manual files. Both P3 and P4 relied extensively on Microsoft Excel spreadsheets to track traditional method and online social media (Facebook, LinkedIn, etc.) job postings. P5[1] utilized a Microsoft Excel internal recruitment log to track recruitment vacancy announcements, recruitment job events, and job event turnouts.

Interview question 2: How do you differentiate your successful recruitment strategies from less successful methods? All participants used outcomes to assess and differentiate the success of each recruitment activity. Participants based the measurement on the amount of qualified applicants that responded to job announcements, how many positions were secured, and the length of individual's employment tenure with the organization. Participants determined the quality of a qualified applicant by education, years of experience, and the interview process. Therefore, if a recruitment method was less favorable in receiving qualified applicants, the leaders built on strategies for future advancements.

Interview question 3: What are some of your organization's most successful recruitment strategies for RNs? P1, P2, and P3 responded that word-of-mouth from nursing students and personal networking from employees have been the best advertising recruitment strategies to recruit RNs. P3 revealed that most of their recruits come from online recruitment websites such as Indeed.com, Hirelogy, and the company's Facebook page. P4 used internal promotion and empowered their LPNs to continued education to fill RN vacancies. C5's strength lay in on-the-spot interviews and their valor program. P5[1] explained the valor program as:

> A program when students are in their junior year, they get to come and work for the summer. We usually hire three per year, and once they have worked in the valor program, several of them will come back to us to get regular jobs and work regular RN positions.

P1 and P2 also stated that they had successful recruitment benefits and rewards from their clinical nursing student groups to fill several RN positions. Student nursing programs offer P1, P2, and P5[1] first pick of soon-to-be RNs that they helped to train. P1 elaborated that their clinical nursing program gives nursing students the opportunity to acquire the skills and knowledge that are only learned through experience. During clinicals, students get to learn the facility's working dynamics and day-to-day expectations where they work alongside experienced RN preceptors. Students also learn conflict resolutions, opportunities for enhanced specializations and develop interprofessional collaborative skills, help to get the job students want, and the facility gets to see the students in action and hire better-trained nurses. P1 stated, "if it is not word-of-mouth advertising, then it's working with those students' groups that have been most successful for us." P1, P2, and P5 all corroborated the gains from recruitment fairs.

Interview question 4: What are some of the barriers that you have encountered in implementing recruitment and retention strategies? How were those addressed? All participants highlighted and acknowledged the nursing shortage and the demand for RNs and competing for RNs with other healthcare facilities as two of the main barriers they have encountered and are facing in recruitment and retention strategies. C1's barriers included several cumulative effects such as healthcare changes, the economy, baby boomers retiring, available job opportunities, RNs work schedule (night and weekend shifts), and inconsistent financial budget constraints. P1 noted that the barriers they faced were overcome by recruiting out-of-state, secured positions early through their student nursing program, rotated staff to where they are needed the most,

and strategically utilized their budget for recruitment bonuses or recruitment relocation fees.

C2's barriers were job websites malfunctions and the website not being user-friendly, limited mentoring programs, no pay for prior or advanced education, and no employee recognition programs because the organization is very patient-focused and mission driven. P2 pointed out that they are currently working on improvements to the job website and working on bringing more awareness to higher ups about the lack of incentives for higher education and discuss options. P2 admitted to getting several questions from applicants on pay for previous education.

C3's main barrier was the nursing shortage. P3 revealed that "the nursing shortage has hindered us from getting a lot of qualified nurses. So we just have to keep looking until we find a good fit." As a result of the nursing shortage, closure of a nearby nursing school resulting in less nursing graduates, C4 competes internally for RNs. On the contrary, C5 is located in the vicinity of several other healthcare facilities and competes externally with other healthcare facilities for RNs. C5 uses its benefits to attract RN applicants and to retain them. These benefits include prestigious leave opportunities, health insurance coverage that is transferrable into retirement, recruitment bonuses, and 12-hour work shifts.

Interview question 5: What are some of your current recruitment and retention barriers? How are you addressing those? P1 and P5 indicated that the same barriers in the past are also currently the same barriers they experience; said barriers often repeat, rotate depending on the season, or what is happening in the job market. Past

methods are often drawn upon to address the same barriers with slight modifications. Some of the current recruitment and retention barriers that C2 experiences are multiple retirements in a given year, not being the high payers regarding compensation, turnover based on personal reasons, relocations, or bad managers. In 2016, C2 lost 30 RNs to retirement, 39 RNs resigned, lost 15 new hires, and terminated 13; therefore, in one year C2 lost a total of 97 RNs. In comparison, the numbers were not favorable for C1 as their turnover rate in 2016 went from 6% to 13% as a result of a nursing strike.

P2 acknowledged that many of the company's retention issues are uncontrollable (i.e. retirement, personal reasons, and relocations). P2 highlighted the challenges in addressing bad managers are still a work in progress and said, "it's difficult for leadership to address those kinds of issues with their peers. Those managers that need help don't realize it or whatever; they have a high turnover in their units – it is frustrating in my role."

The barriers that C3 experienced were the locations of jobs and the drive time for employees, multiple turnovers which spark more applicant interviews, new hires lacking the endurance to see through job assignments, and the organization not being Medicare certified to attract certain Medicare eligible patients. C3's recruitment and retention efforts are offering a variety of assignments, procedures, and treatments, flexible work schedules, one-to-one patient care, assisting with drug studies, continuing education, and weekly pay. To be Medicare certified the healthcare facility needs to have certain applicable laws, regulations, and compliance information defined in the Social Security Act, and C3 does not fall into that category.

C4's main barrier is pay differences in the company. P4 indicated "within the clinic setting, the pay rate is substantially lower than in an inpatient or long-term care setting." The company's administration and HR are aware of the pay rate differences and a solution is a work-in-progress. P4 signified that resolutions to the pay differential issues are not anticipated to come quickly in the near future as there are many obstacles to overcome.

P5[1] added that as part of their qualification standards (which is a government decision), they cannot hire individuals from non-accredited programs or institutions. P5[1] noted, "unfortunately a lot of the applicants that apply here are from non-accredited programs that we cannot hire." All participants have declared that as a result of the nursing shortage they do take notes and pay attention to trends or what their other healthcare facility competitors are doing to stay abreast or ahead to recruit and maintain RNs.

Interview question 6: What are some of your organization's recruitment strategies that have not been successful? Why were they not successful? P1 and P2 explained they had attended a host of career fairs in their long recruitment tenure and a few of them have proven to be futile, namely because of the wrong target group or little or no interaction with nursing students. P2 went on to clarify that in this technological age, many of the nursing students are not attending job fairs and prefer to get information online. P2 described "they don't need to talk to a recruiter. I think presenting yourself to a recruiter is very advantageous because the recruiter will remember the applicants and

they can hand in their resumes in person, and they can talk about why they want to work with the organization. And that means something; it is a face-to-face interaction."

While on-the-spot interviews work wonders for C5, P1 found that on-the-spot interviews especially done at career fairs, in the long haul, were unsuccessful for them. The main reasons the on-the-spot interviews were unsuccessful for C1 was that there was not enough time to find out if applicants would be a good fit for the organization or to learn of both parties' expectations. P1 remarked, "uh, we probably should have dug a little deeper." Similarly, from time-to-time P3 stumbles upon assignments that are challenging to fill and have to explore all possible avenues to get those positions filled; this means posting job announcements on Craigslist. P3 has often found that they do not get the best applicants or hires from Craigslist. P3 mentioned "Craigslist is not a good hiring website. We just don't get good applicants from Craigslist. We try not to use that one much unless we really cannot get anyone else from other resources."

P4 and $P5^2$ both place recruitment advertising and job fair announcements in local newspapers. P4 and $P5^2$ have realized that these are not always effective actions. Sometimes newspaper advertising is a hit or huge miss because the target audience does not see or is aware of the newspaper advertising. $P5^2$ said, "I am not sure how many people read the newspaper." $P5^2$ further explained that when advertising is a miss, job fair attendances are extremely low.

Interview question 7: How do you track RNs leaving your organization? All companies track RNs leaving their organizations. P1, P2, P4, and $P5^1$ employed

electronic exit surveys/interviews to track RNs leaving. P3 used per diem as a tracking mechanism.

Interview question 8: What are some of the common themes or reasons RNs leave? P1, P2, P4, and P5[1] alluded that not all RNs leaving complete the exit surveys/interviews. C1's principal reason for RNs leaving is that employees found another job elsewhere. C2's reason was predominantly with management. P3 indicated that employees frequently complain about work site drive times and wanting full-time status. C4's major reason for RNs leaving was for more money elsewhere. C5's common themes were employees wanting that hospital experience/specialty, more money, family relocation, childbirth, and needing part-time hours. P1, P2, P5[1], and P5[2] testified that RNs leave, but they come back to work with the organizations in 3-5 years.

Interview question 9: What are some of the characteristics of RNs who stay versus RNs that leave? In what ways do you screen for those characteristics when recruiting? All participants spoke on the characteristics of RNs that they see employed with the organizations for over 2 years. P1-P5 attested that the love for the patients and the passion for helping others are magnificent signs and characteristics of great RNs. P1 gains employment longevity from their nursing student groups, employees who like innovation, progression, team collaboration dynamics, and career and educational advancements. C1's, C2's, C3's, and C5's benefits lure and help to retain RNs for the long haul. In addition, P4 signified that engaged employees stick around with the organization as well.

All the organizations primarily scan for the above RNs' characteristics in their interview processes. C1's orientation for a new RN hire is at least 8 weeks depending on the specialty department. P1 highlighted that the orientation assessment is also incorporated to discern RNs as to where they are best suited and how they fit all together in the organization's culture. C1 is associated with the Magnet recognition program. The Magnet recognition award is given by the American Nurses' Credentialing Center (ANCC) to hospitals that satisfy certain criteria designed to measure strength and quality of their nursing (Rodwell & Demir, 2013). C2 characteristics screening commences as early as in the pre-screening application stage.

Emerging Themes

In the following section, I will discuss the results of the study by emerging themes. There are two major themes and four sub-themes. The two major themes that emerged as strategies taken by the healthcare facility leaders were: (a) recruitment strategies and (b) retention incentives. The four sub-themes: (a) job opportunity/recruitment, (b) student clinical, (c) patient focused, and (d) turnover/leave formulated the themes. Theme 1 is recruitment strategy. The sub-themes under recruitment strategy are: job opportunity, student/clinical, and patient focused. Theme 2 is retention incentives. The sub-themes under retention incentives are job opportunity, patient focused, and turnover/leave. There were overlapping sub-themes in both major themes. The overlapping sub-themes are job opportunity and patient focused. The major themes contained the four sub-themes.

Theme 1: Recruitment Strategies

Recruitment is an activity that organizations conduct to gain qualified employees to perform the organization's mission, goals, and responsibilities. The recruitment strategies performed by all the study's participants indicated that regardless of the worldwide nursing shortage, the study's participants continuously forge ahead to recruit RNs. Organizations have to be strategically creative in their recruitment tactics. All participants concurred that the RNs that fit perfectly in their healthcare facilities are the RNs that are invested in helping the patients and want to improve their care, whether it is end of life or beginning of life. The interview moment is a crucial time for managers and leaders to gauge RNs based on past experiences. When RNs show these types of characters, it is a win-win for everyone involved. P1 said,

> But it is really a time for the manager too to talk about the unit or area; talk about what opportunities there are for professional development; talk about the expectations and the daily routines; talk about who the nurses work with closely in the area. So really to give them a feel of this is the area you would be working in and now based upon what you have said, let's see if that will be a good fit.

Recruitment strategies are deemed successful by all participants based on the outcomes or end results of the recruitment process. Outcomes include the number of applications received, interviews held, available positions filled, and employment tenure. All participants declared they offer recruitment incentives such as recruitment bonuses and relocation fees from time-to-time to fill hard to fill job vacancies. In 2016, P2 spent

a total of $831,809 in recruitment/relocation incentives to fill 33 critical nursing positions.

Not all nurses are actively looking for jobs, and sometimes those nurses are the ones whose attention organizations want to get. P2 pointed out that OR nurses and critical care nurses are difficult to recruit for as they are usually happy in their jobs and stay in their jobs for a long time. "You have to go show them to themselves; you have to get in their face so to speak," mentioned P2. Participants implied that employers are aware that the ball is no longer solely in their court, but job seekers have some power in what they will negotiate on in the recruitment process, and expectations on both sides should be clear. Hence the RN battle continues with healthcare facilities competing for the same RNs. All participants have acknowledged utilizing some form of recruitment measurement and resources to keep organized and on top of their recruitment plans.

Word-of-mouth is one of the oldest networking techniques and is still effective as one of the best recruitment strategies to recruit RNs. Word-of-mouth transpired through employee networking with peers, friends, and family members, local radio advertising, job fairs, and individuals sharing their experiences or knowledge about on-the-job student nursing programs or residencies. The majority of participants seize full advantage of their student nursing programs; however, experienced nurses are in demand. Student nursing programs allow nursing students to practice critical thinking skills in a non-threatening and supportive environment, and also provide nursing students the opportunity to understand the depth and breadth of what nursing has to offer and be ready for the nursing career profession. P1 validated that in 2016 they had over 560 nursing

students doing clinicals and clinicals are helpful where nursing students get the opportunity to see the culture, and that is one of the best ways to introduce students to the organization. P1 responded, "it's like an on the job interview almost, where we can see them, and they can see us and they get a feel for the place." P1 shared that as a result of a national wide survey that discussed patients that are cared for at hospitals with nurses who have a baccalaureate degree have better patient outcomes, currently C1 is exclusively hiring nurses who have a 4-year degree.

Theme 2: Retention Incentives

Multiple healthcare facilities are contending for the same individuals for employment. Depending on what each organization is providing and what applicants' desire, will determine which organization RNs will accept job offers. All the study's participants acknowledged that the fringe benefits are what initially attract RNs to an organization, and the benefits are the same assets that may retain them. Participants concluded that individuals begin to seek employment elsewhere when a desire is lacking with their present employer. P5[1] illustrated "many of our employees here are younger and are of childbearing age, and once they have children they tend to want part-time status, which is not always available, and so they leave the organization to go where that need can be met." The participants unanimously agreed that many times RNs leave for another job opportunity with a better schedule. New nurses usually have to work night shifts and every other weekend. P1 mentioned, "This is where it is hard; we are a hospital that opens 24-hours, 7-days a week and we need RNs every day, nights, and even on the weekends." Benefits play an integral part to find flexible schedule for RNs. RNs

employed at C1 can make extra money for nights and weekend coverages, for being a charge nurse, for being a preceptor, for working on the holidays, and also working on their birthdays.

The study's participants cited that money is another factor that may lure, keep, or drive away RNs. The union, education and prior work experiences assist to determine pay rate for many RNs at C1, C2, and C5. Different career options play another influence in retaining RNs. P1 highlighted that across the United States the economy is good where there is a multitude of other career choices that might entice RNs to leave the nursing field. All participants further added that this is where the compelling passion for helping others kicks in to sustain RNs in nursing or to bring them back if they happened to leave.

C1's leaders are being challenged and encouraged to get to 80% of their nursing staff to be baccalaureate prepared by 2020. In the wake of this challenge, C1 has partnered with many other universities and colleges in the Twin Cities and is offering 15 $7,500-10,000 scholarships as incentives to encourage nurses to go back to school or to continue to a bachelor of science in nursing (BSN) degree.

Other retention efforts distinguished by the participants are scholarships for continued education, special organizational committees RNs can join for research practices or drug studies, and offering 8-12 hour shifts in certain areas. P1, P2, and P5 noticed that they received plenty of applications for 8-12 hour shifts vacancy announcements, and RNs are quick to rotate to areas with 8-hour shifts. P1, P2, and P5[1] observed that if they can keep RNs for 3 years or more, that will turn into 5 years and

usually after 5 years, they will stay for the 10-20 years. P2 and P5[1] boasted that RNs have another impressive benefit working with their organizations, in that RNs can transfer to any of their locations in the United States with the same Minnesota RN license.

RNs leave for various reasons, many of which are uncontrollable by the organizations. When RNs leave for uncontrollable reasons, organizational retention incentives are ineffective. The three key uncontrollable reasons gathered from participants are retirement, personal reasons, and family relocations. P1 and P2 voiced that many of their baby boomers RNs have extended working longer as a result of the nursing shortage, and when they cannot continue employment anymore for whatever reasons, they will suddenly retire. Similarly, for personal reasons and relocation, RNs often relocate because another family member (spouse or significant other) has a job opportunity elsewhere and by default, the RN has to follow that family member. All six participants stressed that RNs that are connected to the organizations' missions and are patient-centered, have seen employment longevity with their organizations.

Literature Review and Conceptual Framework Application

Healthcare facility leaders in Central Minnesota are not oblivious to the nursing shortage. All the study participants raised awareness to the issue and the pressures of the nursing shortage as validated by Chan, Tam, Lung, Wong, and Chau (2013), Itzhaki, Ehrenfeld, and Fitzpatrick (2012), and Twigg and McCullough (2014). In comparison with prior research done by Auerbach et al. (2013), Bureau of Labor Statistics, (2015); Havens, Warshawsky, and Vasey (2013), and Rezaei-Adaryani, Salsali, and Mohammadi

(2012), all participants comprehended that the nursing shortage is worldwide, and that other healthcare facilities are facing challenges to recruit and retain qualified nurses. Participants underlined that retirement eligible nurses are not retiring as soon as expected. baby boomers are the oldest generation in the workforce (Budden et al., 2013; Ortman, Velkoff, & Hogan, 2014; Bureau of Labor Statistics, 2013). Baby boomers' retirement put a noticeable reduction in the participating company RN workforce. Sufficient RN staffing levels help to maintain job satisfaction (Kalisch & Lee, 2013).

Nursing schools are valuable in developing nurses. The literature review highlighted the insufficient nursing faculty staff continues to put a strain on the nursing workforce size and is contributing to the nursing shortage (Cox, Willis & Coustasse, 2014; Gerolamo et al., 2014). C1 and C5 experienced nursing school closures, which affected their nursing recruitment plans. P1, P2, and P5 confirmed with Zinne et al. (2012) that student nursing programs increase retention, decrease turnover, and allow for a safe and supportive learning environment for nursing students and new graduate nurses. As noted by Clipper and Cherry (2015), Rush, Adamack, Gordon, Lilly, and Jank (2013), and Zinne et al. (2012), P1 also supported that a lot of turnover for new hire nurses occurs in 1-2 years post-hire.

Even though healthcare facilities in Central Minnesota offer 8-12 hour work shifts for nurses, nurses can work more than 12 hours per shift in some areas. P1, P2, and P5 hinted to work overload or nurse burnout by RNs gravitating more to 8-12 hour work shifts or requesting part-time statuses. From the literature review multiple researchers have supported that nurses work extensive shifts which can lead to physical, mental, and

emotional exhaustion, disengagement, job dissatisfaction, patient dissatisfaction, and intention to leave the job (Domen, Connelly, & Spence, 2015; Sanchez, Valdez, & Johnson, 2014; Stimpfel et al., 2012; Townsend & Anderson, 2013). Shift work and night shifts have negative influences on nurses' health and well-being (Buja et al., 2013).

The Herzberg (1959) two-factor theory is the study's conceptual framework. Herzberg's theory symbolizes several factors that may affect job satisfaction and job dissatisfaction. Job satisfaction and job dissatisfaction are fundamental to the employees' retention and turnover (Herzberg, 1959; Han, Trinkoff & Gurses, 2015). In connection with Atefi et al., (2014), Buja et al., (2013), Choi et al., (2013), Hackman and Oldham (1976), Smith and Shields (2013), participants' responses concurred that hygiene factors are primarily causing dissatisfaction for RNs. These hygiene factors include the rate of pay, personal reasons, and working conditions that are causing RNs to leave. Job dissatisfaction is a predictor of intent to leave and job turnover (Abiodun et al., 2014; McHugh and Ma, 2014; Smith & Shields, 2013). Turnover leads to massive waste of organizational resources in the healthcare industry (Roberts-Turner et al., 2014; Sokhanvar, Hasanpoor, Hajihashemi, Kakemam, 2016). P3 admitted to constant interviews and new hire training as a result of high employee turnover.

While hygiene factors are driving most participants' RNs to leave, motivational factors are retaining or bringing RNs back. A decent wage is not always a significant factor for some nurses, as nurses enter the nursing profession with a passion for caring for others (Buja et al., 2013; Hussain, Rivers, Glover, & Fottler, 2012; McHugh & Ma, 2014; Sinha and Trivedi, 2014). When nurses are engaged, invested in their patients and

encountered job satisfaction, intent to stay is increased and job search behavior decreased (Albdour, & Altarawneh, 2014; Al-Hamdan, Manojlovich, & Tanima, 2016; Buja et al., 2013; Carter and Tourangeau, 2012; Kazimoto, 2016; Norman, Rossillo, & Skelton, 2016). Hoye (2013) discovered that satisfied employees are intrinsically motivated to give positive referrals. Wolfe (2014) indicated that word-of-mouth can provide positive source of information for recruitment. Most participants validated that word-of-mouth and networking have been their best recruitment strategies. Fringe Benefits and incentives are part of job satisfaction and assist in the support to recruit and retain nurses (Atefi, 2014).

Applications to Professional Practice

The main objective of this study was to determine the strategies healthcare facility leaders use to deal with the shortages of RNs. The findings challenge current thinking and business practice by recommending creative and strategic recruitment and retention strategies for RNs. The findings from this study may contribute to business practices by improving healthcare facility leaders' understanding and knowledge of successful strategies to retain and recruit RNs. The nursing profession remains central to achieve care that is effective, safe, and efficient (Hertz & Santy-Tomlinson, 2017; Spetz, 2016). The themes that came from participants indicated that effective recruitment strategies and retention incentives could significantly combat the nursing shortage.

A fundamental aspect of marketing is finding the appropriate target audience to market to (Grossberg, 2016). Knowing where and how to reach one's target audience then becomes vital in ensuring that nursing students or RNs job seekers are aware of job

opportunities whether through word-of-mouth, career fairs, radio advertising, websites, etc. Career fairs are not effective if the advertising is wrong. P1, P2, P3, P4, P5[1], and P5[2] expressed that if they do not advertise to the right group of people, then the turnout or outcome is inauspicious. The majority of the study's participants could not hire applicants from non-accredited schools. Preferable requirements of RN positions should be clearly stated with position announcements to limit or discourage unqualified applicants from applying for RN vacancies. In addition, recruitment software can aid to weed out applicants who do not meet the minimum requirements before moving forward to a recruiter.

Working directly with accredited nursing schools, nurses' associations, or job agencies could improve business practice. Email blasts could be sent to nursing schools to circulate to juniors and seniors who are looking for an internship or a job. Working directly with nursing students for C1, C2, and C5 have been very instrumental in recruiting and retaining RNs. The benefits are favorable when organizations recruit nursing students when they are earlier on in nursing programs or by offering them scholarships while they are actually in schools before they become part of the organization (Rossler & Bennett, 2017; Trepanier, Mainous, Africa, & Shinners, 2017).

From participants' responses, there is a golden timeframe to try and retain nurses. If healthcare facility leaders can get nurses to last 3 years, then leaders can get nurses to 5 years and then longer for those 10-20 years. Therefore, healthcare facility leaders should earnestly strive to get nurses in the door and need to aim to keep nurses satisfied and engaged for at least 5 years. After 5 years, a majority of the nurses will stick around for

the long haul. During the first 5 years is when the indoctrination period commences where leaders have new nurses get to know the managers, the staff, and conduct team building exercises. The indoctrination period sets the tone for nursing students and new hires to learn about the organization's culture and helping new hires to find out the dynamics and the values of the organizations implemented by managers and leaders.

All participants communicated that benefits are important to RNs. Some of these benefits include the rate of pay, flexible working hours, incentives, and scholarships. It becomes advantageous for organizations to offer benefits that are attractive to its specific nursing staff or target group. Many healthcare facilities are competing for the same staff, and the benefits on the other side of the grass may lure nurses away, especially when nurses become dissatisfied. Participants mentioned the constant battle of their nursing staff requesting work status changes depending on personal issues. Nurses want to go from full-time to part-time, and vice versa.

In this 21st-century dynamic health system, information technology plays an important role in recruiting RNs (Darvish, Bahramnezhad, Keyhanian, & Navidhamidi, 2014). P2, P3, and P4 addressed that applicants prefer searching for job opportunities online. Employment websites or pages must be user-friendly, workable, and easy for applicants to find where they need to go and what they need to do is going to be key. For example, have noticeable buttons that say "apply here," "employees wanted click here," or a have a banner that says "well here is where you can go for an on-the-spot interview to get interviewed today," or "job fairs." Participants referred to the value of asking applicant more in-depth questions in interviews to distinguish candidates who may be a

"good match" for the organization's culture, mission, and employment longevity. For illustration "why do you want to work here?" or "where do you see yourself in 5 years?" Questions such as these help nurse recruiters to locate those individuals who will be engaged and patient-centered nurses. This study may help healthcare facility leaders to examine the way they recruit and retain nurses and help those leaders to overcome new challenges when turnover transpires.

Implications for Social Change

The results of this study may provide healthcare facility leaders with additional information on how to successfully recruit and retain qualified RNs. Effective tactical recruitment strategies and access to resources can lead to increasing the nursing workforce and have a positive effect on retention. Community outreach through nursing schools is useful in advertising healthcare facilities' student nursing programs and RN positions. On-the-job nursing programs and residencies have proven to be instrumental in supplying organizations with RNs. Positive word-of-mouth advertising from nursing students, RNs, and nursing staff can directly save additional marketing costs for organizations. Dissatisfied RNs portray a negative image and do not recommend their organizations to family or friends (Stimpfel et al., 2012). Improving nurses' satisfaction, working conditions, and benefits will positively affect the solidity of the nursing workforce in the future. When RNs are satisfied, engaged, and happy on the job, they are more likely to provide better customer service and increased patient satisfaction.

When recruitment efforts have confirmed to be lacking, corrective action helps to reduce the likelihood of another failed career fair, advertisement, etc. Patient care is at

risk when the nursing workforce is short staffed. Promoting the significance and the reward of being a nurse may increase job growth in the community. In essence, if healthcare facility leaders are more focused on getting more RNs and keeping them satisfied for at least 5 years, they are more likely to see an increase in productivity, patient satisfaction, less turnover, better relationships, improved professional and personal lives, and decreased safety issues. Other implications for positive social change is by having an ample supply of RNs that would contribute to more satisfied RNs and families, as well as help the local communities and the economy as a whole. If healthcare facility leaders can extend quality focus to lessen the nursing shortage by proactively recruiting and ensuring that more RNs are engaged and satisfied, this will lead to a larger and potentially satisfied nursing profession. In addition to the potential increases in job satisfaction, comes the potential for improved quality care for patients in the population as a whole. Nurses are essential positions to initiate change and lead as prime care coordinators of inter-professional teams, which care for patients and their families.

Recommendations for Action

Each healthcare facility is unique with a distinct set of factors that determine its mission, services rendered to patients, and strategies to compete successfully in the healthcare industry. To ensure success, healthcare facility leaders must establish key performance indicators to evaluate the effectiveness of their recruitment and retention strategies. Healthcare facility leaders and recruiting departments should take note of the participating organizations' strategies in recruiting and retaining RNs. The individuals interviewed are observing and learning mostly from what other local or out-of-state

healthcare facilities are doing so that they can compete for qualified RNs and strengthen their nursing workforce. Healthcare facility leaders that are interested in recruiting and retaining qualified and satisfied RNs may benefit from this information. I recommend the following actions based on the results of this study:

- Organizational leaders in healthcare facilities should ensure that nurse recruiters and hiring managers improve their hiring skills and are properly trained on up-to-date best practices to recruit qualified RNs.
- Healthcare facility leaders, RN, and nursing schools should promote nursing to the public that RNs are trained life-saving professionals and that the nursing profession has many different possibilities. The public image of nursing is diverse and filled with negative stereotypes. A positive image of nursing increases the chances that individuals would opt for a nursing career.
- Local and federal governments can also support to raise awareness of the dire need for more RNs and establish a career development fund that offers grants and scholarships to attract more individuals to enter the nursing profession.
- Healthcare facility leaders need to be creative, proactive, and apply critical thinking to hire more qualified RNs for a healthy supply of RNs. The shortage of RN personnel affect opportunities for providing quality nursing care. Furthermore, the shortage puts a strain on existing RNs which leads to burnout, job dissatisfaction, and intention to leave.

- A shortage of RNs persists. Healthcare facility leaders should start offering more RN positions early while nursing students are in their senior years in nursing school.
- Job rotation, extending professional autonomy on the job, opportunities for interpersonal learning, and peer consultation can help RNs to become more satisfied on the job which may aid in retention.
- Healthcare facility leaders should increase and sustain programs to support nursing students and new RN hires (e.g. residencies, clinicals, preceptors, mentoring programs, research committees, etc.) on the job. New RNs and student nurses learn from their work experiences through interaction with other nurses.
- Nurses are educators and role models who are essential to the process of creating a professional identity. Healthcare facility leaders should maintain strong leadership work environments to create a satisfying and engaging workforce for RNs.
- Healthcare facility leaders should groom and encourage LPNs to the next level to become RNs. Leaders can also offer tuition assistance and scholarships as financial support.
- Compensation and benefits are influential factors in recruitment and retention efforts. Healthcare facility leaders must compensate and reward RNs accordingly to remain competitive in the healthcare industry.

- Healthcare facility leaders could offer job-sharing opportunities to RNs who want to change their work status from full-time to part-time. Job-sharing opportunities allow for leaders to retain talent rather than RNs going to another organization or possibly changing profession because of part-time status denial.
- Healthcare facility leaders can enact a phased retirement plan to ensure smooth and efficient transfer of knowledge of baby boomers RNs. Succession planning then becomes crucial when planning for retirement eligible nurses.
- The research findings and recommendations can encourage governments to integrate statutory requirements and standards for mandating less than 12-hour work shifts for RNs. The literature has indicated that RNs that work more than 12-hour work shifts are prone to making more mistakes on the job, burnout, etc. Less than 12-hour work shifts promote safe work environments and better patient outcomes. Government revenue is increased through taxes from employees' longevity in the labor force. In addition, the government could benefit because healthy employees use their intellectual capital for national development.

The results of this study could be distributed through lectures, workshops, to healthcare facility leaders and professionals through training, or professional publications. The results could also be discussed at various professional conferences, and could also circulate through scholarly and business journals.

Recommendations for Further Research

A large amount of research about the nursing shortage exists; however, research on successful strategies to recruit and retain qualified RNs is limited. The literature indicated that for decades healthcare facilities have grappled with dealing with the shortages of RNs. Continued studies regarding the recruitment and retention side of the nursing shortage should be explored to address areas not addressed in the study and to review delimitations. My motivation for this study was to highlight strategies that healthcare facility leaders use to recruit and retain RNs because no wide recruitment or retention measure standard exists. I recommend further study to determine a conclusive set of key indicators that business leaders may exercise that are transferable to businesses in any industry.

Opportunities for further studies could divulge information associated with researching the views of RNs in healthcare facilities. The limitations of this study were the geographical location and the small number of cases. Another recommendation would be to perform multi-case studies in other states in the United States. Future studies could be performed in other parts of the world to gain a broader perspective of alternative recruitment and retention strategies. Additionally, researchers in different geographical locations could partner together to magnify the study into a worldwide study. Furthermore, multiple research methods could be performed to expand the existing findings and improve validity that could add further insight into recruiting and retaining qualified RNs. Finally, the proposed topics for additional research may assist healthcare

facility leaders to focus attention on the factors with significant impact on recruitment and retention strategies for RNs.

Reflections

The DBA doctoral process is a controlled process which was quite overwhelming at times and also enjoyable. When I started this journey, I was not aware of how challenging this process would have been. This research was rigorous and revealing. I chose the research topic from the standpoint of being a very concerned citizen after reading a couple of articles while initially searching for a business topic for my study. I have no experience with recruiting or retaining RNs or had I met any of the participants before the interview which helped to decrease bias. Before the research, I ensured that I acquainted myself with the concept of research bias. After learning about research bias and the DBA doctoral process, my biases had no impact on the research findings. The research findings aligned with the research evidence, which includes audio-recorded interviews, interview transcripts, my reflective journal notes, company documents, and companies' websites.

Central Minnesota has multiple healthcare facilities, especially in the Twin Cities. The shortage of nurses in Minnesota is not a topic that is advertised well to the public for awareness. All participants discussed the struggles of finding and retaining enough qualified RNs. I found it interesting how passionately all participants spoke about the nursing profession, especially RNs in particular and that all the participants want things to improve. It was particularly revealing what one company was offering and going above and beyond to attract and keep RNs regarding fringe benefits and incentives, and

that two companies still use actual newspaper advertisings for job announcements. It was also disheartening to find out that one company is so patient driven that in the midst of it all, there are no recognition programs for valuable nursing staff. In relation to the nursing shortage, a few participants seemed nonchalant in their roles as nurse recruiters rather than being proactive in addressing specific recruitment and retention issues, for example retirement and turnover. I discovered that the participants' marketing tactics are somewhat based on what other healthcare facilities are doing to gain a leg-up whenever possible.

After the research, my knowledge on recruiting and retaining RNs has changed. I have been promoting the nursing profession to family members, friends, and acquaintances who are searching for a new or different career path. Research provides authentication, affirmation, and enhance the body of knowledge by collecting first-hand proof. Last but not least, I have the conviction that research can unravel or find a solution to any business problem.

Conclusion

Nursing is the largest health profession and nurses are the heartbeat to the health of the nation. The quality of the healthcare system is dependent upon nurses. Everyone's part is necessary to continue to encourage our younger generation into the nursing profession. Guidance and support from both nursing faculty and employment leadership weigh heavily from the moment an individual enters into nursing school to become a nurse on the job. Recruitment and retention strategies magnetize RNs; however, these strategies vary depending on the organizations' goals, standards, and financial budgets.

The ownership is upon governments and healthcare leaders to ensure that more RNs continue to have the compelling desire to have longevity in the nursing profession, and also to feel valued and satisfied in their work environment and compensation. Nurses are the hospitality of healthcare. It is a win-win situation for healthcare facilities, RNs, and patients when nursing staff is qualified, satisfied on the job, and nursing staff is sufficient to meet patient care and effect positive economic and social change.

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Appendix A: Interview Protocol

INTERVIEW PROTOCOL

- Arrive approximately 5-10 minutes prior to interview time to set up recording device and prepare paperwork.
- Confirm receipt of CONSENT FORM to and from participant.
- Greet participant upon arrival, thanking them again for their time and offering a beverage (water).
- Briefly explain what will happen during their interview, reminding them that I will be audio recording the entire interview and that if they become uncomfortable or choose to stop participation at any time, they may do so.
- Answer any questions they may have.
- Commence interview with interview instrument.
- Take observation notes during the interview of the participant.
- Upon completion of interview questions, ask the participant if there is anything else they feel is important for me to know or understand. Was there something that I did not ask, or that they would like to elaborate on at this time?
- Shut off recording device, and thank the participant for their interview. Inform the participant that they did a fantastic job.
- Remind the participant about the member checking process that will need to occur. Schedule this appointment time now if they can commit a time slot via face-to-face or on the telephone to do this. Explain the importance of this process in the study, and again thank them for their willingness to participate.

- Part ways with the participant; having scheduled the member checking interview and answering all questions that may have arisen.

Appendix B: Interview Instrument

Interview Questions

- How do you track your recruitment strategies?
- How do you differentiate your successful recruitment strategies from less successful methods?
- What are some of your organization's most successful recruitment strategies for RNs?
- What are some of the barriers that you have encountered in implementing recruitment and retention strategies? How were those addressed?
- What are some of your current recruitment and retention barriers? How are you addressing those?
- What are some of your organization's recruitment strategies that have not been successful? Why were they not successful?
- How do you track RNs leaving your organization?
- What are some of the common themes or reasons why RNs leave?
- What are some common characteristics of RNs who stay versus RNs that leave? In what ways do you screen for those characteristics when recruiting?

Appendix C: Participants' Invite Letter

Dear Sir/Madam,

I am a doctoral candidate at Walden University pursuing a Doctor of Business Administration with a concentration in leadership. I am conducting a qualitative research study as a part of my doctoral study project entitled, *Strategies to Deal with Shortages of Registered Nurses.* With this letter, if you are a healthcare facility leader such as a HR personnel/administrator, nurse supervisor/administrator, or nurse recruiter who has the experience in recruitment and retention of RNs in your organization, I am asking for your participation. Your participation will include a confidential 1-hour discussion of lived experiences on your successful recruitment and retention strategies for RNs. This study, supervised by my committee chair, Dr. Jill Murray, will aid in fulfilling my academic requirements for this degree.

Participants will be asked to share their lived experiences through their own objectivity, intentionality, and perceptions of the strategies that have made them successful. The confidential meetings will be conducted using a standardized open-ended interview approach to understand the problem and seek clarification regarding the phenomena. Based on your acceptance and agreement to participate in this study, please sign and return the attached consent form.

Sincerely,

Appendix D: Letter of Cooperation

Letter of Cooperation

Company's Name
Address
Email:
Phone:

Date

Dear Jody-Kay Peterson,

I have been informed of the purposes of your study and research procedures. I give permission for you to conduct the study entitled "Strategies to Deal with the Shortages of Registered Nurses" within the _____. As part of this study, I authorize you to interview and conduct the necessary research procedures to obtain information on our recruitment and retention practices for Registered Nurses. The individual's participation will be voluntary and at his/her own discretion.

We understand that our organization's responsibilities include personnel and resources. We reserve the right to withdraw from the study at any time if our circumstances change.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University Internal Review Board (IRB).

Sincerely,

_____ _____
Authorized Official Name Authorized Official Signature

_____ _____
Official Title Contact Information